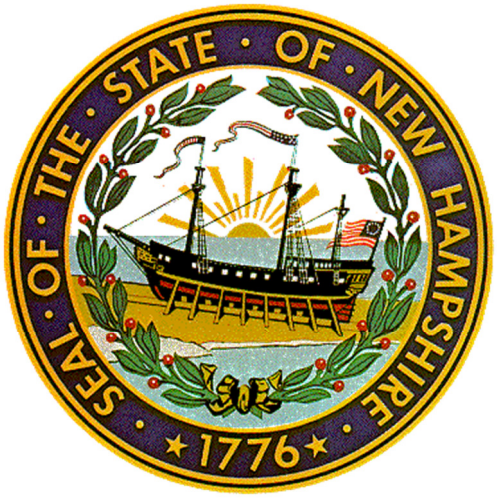

Quality Strategy
for the
New Hampshire Medicaid
Care Management Program

July 8, 2014

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Preface

The New Hampshire Medicaid Care Management (MCM) Quality Strategy is technical document required by the Code of Federal Regulations, CFR438.200, and the Center for Medicare and Medicaid Services programs to ensure the delivery of quality health care by managed care organizations. It is not intended to comprehensively describe all the activities that the Department of Health and Human Services undertakes to ensure Medicaid program quality.

Please forward all comments about the NH MCM Quality Strategy with the phrase "Quality Strategy" in the subject line to: Medicaidquality@dhhs.state.nh.us. Please note, large font versions of this document are available upon request.

I. Introduction

A. General Information

The 2011 the New Hampshire (NH) State Legislature directed the Commissioner of the Department of Health and Human Services (DHHS, the Department) to develop a comprehensive statewide managed care program for all Medicaid program enrollees. (Public Health, Chapter 126-A, NH MCO Contract Section XIX). The goals of the newly established Medicaid Care Management program are to offer "the best value, quality assurance, and efficiency, maximizing the potential for savings, and presenting the most innovative approach" to the provision of health services for the State's Medicaid beneficiaries.

The Medicaid Care Management program will be rolled out in three phases (Appendix A). Step One of the Medicaid Care Management program included all State Plan Amendment services, except dental and long term care services, for all NH Medicaid beneficiaries (mandatory for those populations that did not require a waiver for mandatory enrollment). Step One was fully implemented and coverage for enrolled Medicaid beneficiaries began on December 1, 2013.

With Center for Medicare and Medicaid Services (CMS) approval, Step Two will begin mandatory enrollment for all populations and will incorporate, both non-waiver and waiver long term care services into the Medicaid Care Management program.

Step Three, including Medicaid expansion populations resulting from NH's implementation of the Affordable Care Act, will commence August 15, 2014, in advance of Step Two. Senate Bill 413 created the NH Health Protection Program (NHHPP). The NHHPP will expand state supported health insurance through (1) coverage for Medicaid eligible individuals that have access to but cannot afford cost effective, employer sponsored coverage, (2) a Bridge to Marketplace, wherein new eligible Medicaid beneficiaries will be covered under the existing Medicaid Care Management health plans until (3) newly eligible beneficiaries can purchase insurance, which financial support from the federal government, on NH's Health Insurance Exchange. Covered services for the newly eligible population are outlined in Appendix A.

Under state statute, dental services will remain fee-for-service. NH Medicaid beneficiaries who are also part of the VA health system and those spending down to meet Medicaid requirements are currently excluded from the Medicaid Care Management program.

Prior to the initiative of Medicaid managed care, the State has had a disaggregated approach to quality oversight driven primarily by the regulatory requirements of various DHHS programs. Through this NH Medicaid Quality Strategy, NH has begun to coordinate services provided by various health plans into a single, unified approach and building upon the legislative goals of value, quality assurance and efficiency to improve the health of Medicaid beneficiaries.

The State's initial quality objectives will be drawn from generally understood opportunities for improvement. After the Medicaid Care Management program has been established, the Department will perform regular monitoring and analysis to identify the program's successes and new opportunities for improvement and amend the Quality Strategy to include additional population-based quality improvement activities. It is also the Department's intention to, over

time, harmonize the NH Medicaid Quality Strategy with the National Quality Strategy, synergistically using State's resources to champion national campaigns and capitalize on grant and other federal initiatives.

The Quality Strategy will serve to assure stakeholders that the State's managed care organizations (MCOs) are in contract compliance and have committed adequate resources to perform internal monitoring, ongoing quality improvement and actively contribute to health care improvement for the State's most vulnerable citizens.

B. Managed Care Quality Program Objectives

The State's initial quality improvement objectives will be drawn from generally understood NH Medicaid opportunities for improvement and will include four Quality Incentive Projects (QIP) of the State's choosing and four Performance Improvement Projects (PIP) of the MCOs choosing, subject to DHHS approval.

In complement to the State's Quality Strategy, each MCO shall develop, maintain and operate a Quality Assessment and Performance Improvement (QAPI) program, as required by the Code of Federal Regulations, 42 CFR 438.240, and the NH Medicaid Care Management Contract. The QAPI is subject to the approval by the State. Each MCO's QAPI will describe the four MCO performance improvement projects (PIP), at least one of which must have a behavioral health focus. PIP will be based on the MCOs initial assessments of their membership and in consultation with their consumer and provider advisory boards. Additionally, State will conduct quarterly Quality Improvement meetings with the MCO Medical and Quality Improvement Directors. These meetings will routinely bring all of the MCOs together, take an agnostic perspective on the NH Medicaid program, and, to the greatest degree possible, harmonize the PIPs and other quality initiatives across the MCOs and the NH Medicaid program.

For the period from January 1, 2014-December 31, 2014) the following QIP initiatives have been selected by DHHS:

- Prenatal and Post-partum Care (PPC) Timeliness of Prenatal Care Components, a Healthcare Effectiveness Data and Information Set (HEDIS) measure;
- Follow Up After Hospitalization for a Mental Illness Within 7 Days of Discharge, a HEDIS measure;
- Parental Satisfaction with Children Getting Appointments for Care, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure; and
- Satisfaction (Adults) with Getting Appointments for Care, CAHPS measure.

Initial performance targets have been selected for all measures. These targets are based on DHHS expectations of MCO performance against National Quality Compass for Medicaid HMO Data.

For the period from January 1, 2014-December 31, 2014) the following PIPs initiatives have been selected by the MCOs:

- New Hampshire Healthy Families
  - Vision screening for adults with diabetes
  - Well care visits for 3,4,5,and 6 year olds

- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
- Weight assessment & counseling for nutrition and physical activity for children/adolescents

- Well Sense
  - Diabetes Care – HbA1c Testing
  - Percent of Women (16 to 24 years) receiving Chlamydia Screening
  - Well-Child Visits for 3-6 years
  - Reduce Readmissions to New Hampshire Hospital

After the Medicaid Care Management program has been established, the Department will draw from the QIPS, PIPs and other activities to identify additional Medicaid program priorities, strengths and opportunities, and will establish additional program goals. The Department will also incorporate recommendations from the public, MCOs and the External Quality Review Organization (EQRO) Technical Report in setting new goals and revising the Quality Strategy. Other activities at this time include:

- Comprehensive, routine, population-based measurement and monitoring;
- Health plan operations and contract compliance reporting; and
- Annual surveys of member and provider satisfaction with health plans and member satisfaction with Medicaid providers.

MCO QAPI programs will include performance measurement for the above initiatives as well as DHHS required Quality Indicators (Appendix B) and routine reporting on health plan operations (Appendix E). All performance data will be submitted to the State. The State will conduct an initial CAHPS survey to serve as a baseline of standardized information on enrollees' experiences with the NH Medicaid program. Beginning in 2015, each MCO will annually conduct a comprehensive CAHPS survey (NH Medicaid Care Management Contract Section 16.7.3) to continue to assess member satisfaction with the health plans and services. The results of these assessments will be shared with the Department and posted on the State's NH Medicaid Quality Indicators website.

II. Assessment

As required by 42 CFR 438.202(d), the State will assess how well the Care Management program is meeting the objectives outlined in the Introduction through:

A. Analysis of the quality and appropriateness of care and services delivered to enrollees;
B. The level of contract compliance of MCOs; and
C. Monitoring MCO activities through the use of health information technology on an on-going basis.

A. Quality and Appropriateness of Care and Services

New Hampshire assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through:

- NH Medicaid Quality Indicators monitoring (on the NH Medicaid Quality Indicators website, http://nhmedicaidquality.org and Appendix B), including the CMS Pediatric and Adult Quality Measures,
- PIP and QIP projects,
- NH Medicaid Care Management Contract Compliance, Operations and Quality Reporting,
- NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems Population-based, special and ad hoc analysis and reporting,
- MCO National Committee for Quality Assurance (NCQA) accreditation review, and
- External Quality Review Organization (EQRO) activities, including NH Medicaid population analysis and the EQRO Technical Report, and
- NH Medicaid clinical Medicaid Care Management standards.

NH Medicaid Quality Indicators

The NH Medicaid Quality Indicators is a relatively new initiative for the NH Medicaid program, aimed at aggregating population-based measures to enhance the identification of program strengths and opportunities and make this data publicly available on the NH Medicaid Quality Indicator website.

The measures are a selection of standardized and validated measures from recognized and credible organizations including but not limited to the:

- Center for Medicare and Medicaid Services (CMS) including the CMS Adult and Pediatric Quality Indicators (The current measure set includes all of the CMS Adult and Pediatric Quality Indicators that NH Medicaid collects data to report);
- Agency for Healthcare Research and Quality (AHRQ);
- National Center for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS); and
- Center for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS), among others.

The Quality Indicators website is receiving a significant overhaul supported by the CMS Adult Medicaid Quality grant. Reporting capacity will be expanded to include the robust list of Quality Measures (Appendix B) required by the MCOs for Step 1 and the Step 3 related NH Health Protection Program. These changes are further discussed in "NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems."

It is the intent of DHHS to expand this measure set with the implementation of Steps 2 and 3 to include additional measures on physical health, behavioral health, lifestyle measures, and Medicaid services and supports related to home and community-based. The NH Medicaid Quality Indicators website will also include the HEDIS and CAHPS measures for each of the NH Medicaid Care Management programs. To ensure the integrity, reliability, and validity of the MCO encounter data, the State has contracted with its EQRO to audit and validate encounter data and to provide technical assistance to MCOs in collecting and submitting the requested information.

The NH Medicaid Quality Indicators website, and its subsequent iterations, will be updated whenever new data becomes available according to measure specific submission schedules.

Performance Improvement Projects and Quality Incentive Program Initiatives
Each MCO shall develop and implement four MCO performance improvement projects (PIP), subject to the approval of the State, at least one of which must have a behavioral health focus. After each MCO has had the opportunity to make an initial assessment of its membership, and in consultation with their consumer and provider advisory boards, determined the greatest potential for health care quality improvement opportunities, the State will begin quarterly Quality Assurance and Improvement meetings with the MCO Medical and Quality Improvement Directors. These meetings will routinely bring all of the MCOs together, take an agnostic perspective on NH Medicaid program, and, to the greatest degree possible, harmonize the PIPs and other quality initiatives across the MCOs and the NH Medicaid program.

DHHS will annually select four quality improvement initiatives for its NH Medicaid Quality Incentive Program (QIP). For each of the initiatives selected, the MCO will be given performance thresholds and be required to report semi-annually on their progress meeting those targets. These quality incentive initiatives may change each contract year and will reflect both NH Medicaid priorities and achievable targets for the MCOs. For the period from January 1, 2014 through December 31, 2014, the following QIPs have been chosen:

- Prenatal and Post-partum Care (PPC) Timeliness of Prenatal Care Components, a Healthcare Effectiveness Data and Information Set (HEDIS) measure;
- Follow Up After Hospitalization for a Mental Illness Within 7 Days of Discharge, a HEDIS measure;
- Parental Satisfaction with Children Getting Appointments for Care, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure; and
- Satisfaction (Adults) with Getting Appointments for Care, CAHPS measure.

MCO Contract Compliance, Operations and Quality Reporting
The NH Medicaid Care Management Program includes a robust list of Required Quality Reports (Appendix E) and a comprehensive list of encounter data elements (Appendix C). These data will be presented both as individual measures and aggregated into measure sets to demonstrate the impact of specific programs and overall MCO impact in all domains of administrative and clinical quality.

NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems
NH DHHS Office of Medicaid Business and Policy, Bureau of Healthcare Analytics and Data Systems has oversight of data, analysis and reporting. The Bureau currently functions to create routine and ad hoc reports to ensure the delivery of quality care, the development of sound policy and for financial oversight of the Medicaid program. The Bureau will support DHHS reporting on the NH Medicaid Care Management program, including but not be limited to:

- Oversight of the maintenance and aggregation of MCO encounter data (individual beneficiary data) into a single database, which will be accomplished inside the Medicaid Management Information System (MMIS) Reporting Repository;

- Development and oversight of the Medicaid Quality Indicators Systems (MQIS) data, a reporting repository for aggregate data;
- Perform population-wide, DHHS-wide, special and ad hoc analysis reporting;
- Point of contact for MCO data. (Section 24); and
- Assist the EQRO in their oversight of MCO functions and in the creation of statewide, population-based reports on the Medicaid Care Management program.

The NH Medicaid Quality Indicators System website is housed within the Bureau. In December 2012, DHHS received a CMS Adult Medicaid Quality grant allowing the Department to further improve NH Medicaid quality oversight. Specifically, the State's capacity to aggregate and monitor Quality Indicators will be markedly expanded through the development of:

- An enhanced Medicaid Quality Indicators System (MQIS) website with:
  - The capacity to accept data from multiple submitters,
  - The capacity for comprehensive data analysis and routine surveillance of large amounts of data,
  - An ability to automatically flag measures requiring further quality review, and
  - User driven, customized reporting;
- Linking existing data bases for use including the Medicaid administrative data, NH Hospital data and Vital Records data; and
- Expanding State staffing with two new data analysis and two quality program specialists.

MQIS is scheduled to "go live" in the late summer of 2014.

The Bureau is also home for NH's All Payer Claims Database (APCD), the NH Comprehensive Health Care Information System (CHIS). CHIS was created by NH State statute to make health care data "available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices."[1] The same legislation that created the CHIS also enacted statutes that mandated that health insurance carriers, including the new Medicaid MCOs, submit their encrypted health care claims data, Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data to the State. Access to this database allows for robust Medicaid reports and private sector benchmarking.

MCO NCQA Accreditation Review

The NH DHHS required that the contracting MCOs obtain and maintain NCQA accreditation. Additionally, each MCO will conduct an annual HEDIS and CAHPS surveys. The maintenance of accreditation activities and the results of the annual HEDIS and CAHPS will be reviewed and posted on the NH Medicaid Quality Indicators website. The MCOs Annual Report and QAPI reporting will also address activities related to maintenance of NCQA accreditation, identify MCO program strengths and impact, and articulate how opportunities for improvement will be addressed in the upcoming year. The MCO Annual Report and QAPI Report will be posted to the DHHS Medicaid Care Management website.

[1] NH CHIS Welcome website. Accessed at: http://www.nhchis.org/ on July 3, 2012.

External Quality Review Organization Activities

The NH DHHS has contracted with an external quality review organization as required by 42 CFR 438 Subpart E. To comply with Federal regulations, 42 CFR 438.358(b), the federally mandatory EQRO scope of work for the NH Medicaid EQRO includes:

- Validation of Performance Improvement Projects and Quality Incentive Projects;
- Validation of MCO quality performance measures (Appendix B); and
- Preparation of an EQRO Technical Report for each Medicaid managed care plan.

Optional federal EQRO activities required in the NH Medicaid EQRO scope of work include:

- Validation of MCO encounter data submissions;
- Validation of MCO consumer and provider surveys;
- Calculation of NH Medicaid aggregate performance measures in addition to those reported by the MCOs; and
- Performance improvement projects in addition to those conducted by the MCOs, (i.e.: conduction of focused studies of health service delivery issues such as coordination, continuity, access and availability of needed services).

As part of its annual reporting, the State's EQRO will prepare a Technical Report as a compendium of each MCO's plan-specific activities, services and operations adherent to the CMS protocols found in 42 CFR 438.364 for external review quality reports. Specifically the EQRO Technical Report will include:

- An overview of MCO activities, including,
  - A description of the manner in which MCO data was aggregated and analyzed;
  - The conclusions drawn from the data on the quality, timeliness, and access to care provided by the MCO;
  - For each MCO activity reviewed, the EQRO will address:
    - The objective of the MCO activity and the objective of the EQRO oversight function,
    - The technical methods of data collection and analysis,
    - A description of the data obtained, and
    - The conclusions drawn from the data;
- An assessment of each MCOs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO;
- Comparative information across the State's MCO programs;
- Population-based aggregate measurement and analysis; and
- An assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This EQRO activity will commence after the first year of NH Medicaid Care Management program operations.

Each EQRO Technical Report will also include information on trends in health plan enrollment, provider network characteristics, complaints and grievances, identification of special needs populations, trends in utilization, statements of deficiencies and other on-site survey findings,

and financial data, in addition to the scope of work outlined above on projects, performance measures, the quality of the encounter data, and any requested EQRO measures or focused clinical study findings. The EQRO will then compile an executive summary of each MCO, including a summary of each plans strengths and weaknesses. The executive summary and full report will be made available on the New Hampshire Department of Health and Human Services Medicaid Care Management public website.

The Department will use the annual Technical Report to:

- Report Medicaid Care Management program activities;
- Apply sanctions or take other corrective action as designated in the NH Medicaid Care Management Contract,
- Evaluate existing program goals and inform new program goal development; and
- Inform any needed contract amendments or revisions.

Data on Race, Ethnicity and Primary Language

The State currently obtains race (multiple categories), Hispanic ethnicity, and primary language spoken, during its eligibility and NH Medicaid enrollment process. This information will be shared with the MCOs as a part of daily eligibility data feeds.

Data on race, ethnicity and primary language, as well as other demographic and health status information, will be captured more robustly during each MCO's enrollment process via the MCO enrollment form and the new enrollee health risk assessment. The implementation of the State's new MMIS program will allow the State to collect additional information on race, ethnicity and primary language.

NH Medicaid Care Management Clinical Standards and Guidelines

The Department has taken four complementary approaches to establishing high clinical standards and guidelines:

- Compliance with specific federal regulation for Medicaid MCO clinical standards and guidelines,
- Compliance with federal agency and national organizations recommendations and guidelines,
- DHHS review and approval of all MCO standards and guidelines, and
- Comprehensive compliance with federal and state regulatory standards and guidelines.

Consistent with 42 CFR 438.204(g), the NH Medicaid Care Management program has adopted clinical standards and guidelines for access to care, structure and operations, and quality measurement and improvement at least as stringent as in 42 CFR 438 Subpart D. Compliance with these specific standards and guidelines can be found throughout the NH Medicaid Care Management Contract and are catalogued in Appendix D.

The State has built upon the credibility and strength of several federal agencies and national organizations in adopting guidelines for care management. NH Medicaid Care Management Contract Section 10.2.3 of the contract refers MCOs to the Agency for Healthcare Research and Quality guidelines for the development of Patient Centered Medical Homes. NH Medicaid Care Management Contract Section 10.2.4 requires that MCO participate in the development and

support of Health Homes as defined by the Center for Medicare and Medicaid Services. MCO wellness and prevention programs must comport with the American Academy of Pediatrics Bright Futures program recommendations and with all United States Prevention Services Task Force A and B rated prevention and primary services for children and adults.

Section 20.2 of the NH Medicaid Care Management Contract requires the MCOs to adopt evidence-based practice guidelines built upon high quality data and strong evidence. In addition to their standard practice guidelines, MCOs are required to develop additional guidelines to meet the health needs and other opportunities for improvement identified in their Quality Assessment and Performance Improvement programs. All MCO practice guidelines will be subject to DHHS approval prior to the onset of the Medicaid Care Management program and annually thereafter (NH Medicaid Care Management Contract Section 21.1.3). All practice guidelines will be available on the MCO websites (NH Medicaid Care Management Contract Section 20.2.3), and to providers, members and potential members upon request. MCO practice guidelines will be used to inform their coverage decisions, utilization management and member educational activities.

Finally, Section 26 of the NH Medicaid Care Management Contract requires the MCOs, their subcontractors, and their providers to be comprehensively compliant with all applicable federal and state regulation, both present and future. Specific NH Medicaid Care Management Contract Sections also cross reference and require compliance with specific corresponding federal or state regulation as appropriate for that Medicaid Care Management program element.

B. Level of Contract Compliance and How New Hampshire Medicaid Determines Compliance

As required by 42 CFR 438.204(g), the State has established standards in the Medicaid Care Management Contract regarding access to care, structure and operations, and quality measurement and improvement. Appendix D outlines each required component of the federal regulations and identifies the section of the NH Medicaid Care Management Contract where this requirement is addressed. In addition to the federal regulatory standards, the NH Medicaid Care Management standards are present throughout the contract and as discussed in the Quality and Appropriateness of Care and Services section above.

The State will ensure MCO contract compliance in requiring MCO self-regulation and through direct DHHS oversight. NH Medicaid Care Management Contract Section 6.1.1.13 obligates each MCO to have a Compliance Officer whose primary responsibility is the assurance of the program's contractual and regulatory compliance.

Direct DHHS oversight of MCO contract compliance will be the primary responsibility of the NH Medicaid Deputy Director and the NH Medicaid Care Management Account Management Teams, one team for each of the MCOs. The Account Managers will act as a liaison between DHHS and the MCO Compliance Officer on all issues of MCO monitoring. The NH Medicaid Care Management Account Managers will work collaboratively with the cross functioning Medicaid Care Management Quality team and various cross functioning program subject matter experts.

As discussed in the Quality Strategy "Part II. Assessment, A. Quality and Appropriateness of Care and Services," MCO contract compliance and the equally importantly impact of contract compliance on beneficiaries will be monitored by the following activities:

- NH Medicaid Quality Indicators monitoring, including the CMS Pediatric and Adult Quality Measures,
- MCO PIP and QIP projects,
- MCO Contract Compliance, Operations and Quality Reporting (Appendix D),
- NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems population-wide, DHHS wide, special, other and ad hoc analysis and reports,
- MCO NCQA accreditation review, and
- External Quality Review Organization (EQRO) activities, including the EQRO Technical Report and NH Medicaid population wide, aggregated reports

C. The Role of Health Information Technology

New Hampshire assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through the collection and analyses of data from many sources including:

- New Heights - the State's eligibility database
- Medicaid encounter and provider data that will be processed and stored in the MMIS Reporting Repository;
    - National Committee on Quality Assurance (NCQA):
        - The Healthcare Effectiveness Data and Information Set (HEDIS); and
        - The Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- Other data accessible to NH Medicaid, such as the Comprehensive Healthcare Information System database (all payer claims database, managed by NH DHHS);
- Online web access to MCO applications and data to access, analyze, or utilize data captured in the MCO systems and to perform reporting and operational activities;
- External Quality Review Organization's Technical Report; and
- NH Division of Public Health Services implementation of CDC's Behavioral Risk Factor Surveillance System (BRFSS), among others.

In December 2012, DHHS received a CMS Adult Medicaid Quality (AMQ) grant allowing the Department to further improve NH Medicaid quality oversight. The AMQ grant will allow the State to create linkages between existing but underutilized data sets, specifically Medicaid administrative claims data (including encounter data), NH Hospital data and vital records. The AMQ grant requires NH to expand internal resources for data analysis and use, and will fund four additional positions within the Office of Medicaid Business and Policy: two additional data analysts and two new quality program specialists. DHHS will reconfigure the Quality Indicators website, improving the capacity for data examination to include programmed data analysis, routine surveillance of large amounts of data and automatically flagging measures requiring further quality review. Additionally, the Quality Indicators website will allow user-driven, custom reporting directly from the website. These system changes enable DHHS to actively manage over 400 quality measures through the tactical use of HIT and the strategic use of human support as needed. The system enhancements are scheduled to "go live" in the summer of 2014.

The MCOs are required to have information systems capable of collecting, analyzing and submitting the required data and reports. The State's EQRO and pharmacy benefit administrator will ensure the accuracy and validity of the MCO data submitted.

Both Medicaid fee for service and MCO encounter data history for their enrolled members will be provided to each MCO on a regular basis. Enrolled provider data and active service authorization data will also be shared.

While MCOs are not eligible for incentives under the Health Information Technology for Economic and Clinical Health (HITECH) Electronic Health Record (EHR) incentive program, they will benefit from an increase in the meaningful use of EHRs that the HITECH program promotes. In 2013, the New Hampshire Health Information Organization began deployment of a statewide Health Information Exchange (HIE) that would greatly increase capacity of provider-to-provider transmission of health information.

III. Improvement

A. Assessment Based Activities

The State of New Hampshire will initially work to improve the quality of care delivered through the utilization of incentives and disincentives including:

- Contract Activities, including:
  - Quality Incentive Program,
  - Performance Improvement Projects,
  - Payment Reform Incentive Plan, and
  - MCO sanctions;
- Convening Cross-MCO Quality Activities; and
- EQRO Technical Review and Report.

Contract Incentives, Project, Plans and Sanctions

The State's initial quality objectives are drawn from generally understood opportunities for improvement and existing FFS outcomes that should be maintained during the implementation of Medicaid Care Management. Objectives will include four Performance Improvement Projects (PIP) of the State's choosing. For January 1, 2014-December 31, 2014, the following PIP initiatives have been selected by DHHS:

- Timeliness Prenatal and Post-partum Care (PPC): Using the HEDIS measure for Timeliness of Prenatal and Post-partum Care, the MCO will measure the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization and the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. The MCO target will be exceeding 75% of the National Quality Compass National Medicaid CMO rate for the measurement year.
- Follow Up After Hospitalization for a Mental Illness Within 7 Days of Discharge: Using the HEDIS measure for Follow Up After Hospitalization for a Mental Illness Within 7 Days of Discharge, the MCO will measure the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health

disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization within 7 days of inpatient discharge with a mental health practitioner. This rate will include discharges from New Hampshire Hospital. The MCO target will be exceeding 75% of the National Quality Compass National Medicaid CMO rate for the measurement year.

- Parental Satisfaction with Children Getting Appointments for Care: Using the CHAPS measure Getting Needed Care, the MCO will measure responses of "usually" or "always" when parents of child managed care members have been asked "Not counting the times your child needed care right away, how often did you get an appointment at your doctor's office or clinic as soon as you thought your child needed?" The target will be to exceed 90% of the National Quality Compass National Medicaid CMO rate for the measurement year.
- Satisfaction (Adults) with Getting Appointments for Care, CAHPS measure Using the CHAPS measure Getting Needed Care, the MCO will measure responses of "usually" or "always" when managed care members have been asked "Not counting the times you needed care right away, how often did you get an appointment at your doctor's office or clinic as soon as you thought you needed?" The MCO target will be to exceed 90% of the National Quality Compass National Medicaid CMO rate for the measurement year.

Initial performance targets have been selected for all measures. These targets are based on DHHS expectations of MCO performance against National Quality Compass for Medicaid HMO Data.

Each MCO's QAPI program must also include four MCO initiated performance improvement projects (PIP), at least one of which must have a behavioral health focus (NH Medicaid Care Management Contract Section 20.1.11). After the MCO has had the opportunity to make an initial assessment its membership and, in consultation with its member and provider advisory boards, determined the greatest health care quality improvement opportunity for its members, consistent with 42 CFR 438.240, working with the ERQO, the State will biannually review the MCO PIP project proposals.

Section 9 of the NH Medicaid Care Management contract requires each MCO to annually submit and implement payment reform strategies. Beginning July 1, 2014, DHHS will withhold 1% of the total capitation payment amount, which MCOs can then recoup when implementation milestones from the Payment Reform Incentive Plan have been achieved. The MCO payment reform proposals must comply with all state and federal regulations and the NH Medicaid Care Management Contract (Section 9).

The NH Medicaid Care Management Contract addresses remedies at the State's disposal to address MCO performance concerns. Section 32.2 lists the liquidated damages that may be enacted and stratifies MCO violations into 5 levels, each with an associated financial remedy. Category 1, the highest level, for example, would be levied against an MCO for a failure to provide medically necessary services at a cost of $100,000/violation; failure to meet telephone inquiries performance standards is an example of Category 5 violation with a lesser fine of $1,000/violation.

Convening Cross-MCO Quality Activities
The State will convene quarterly Quality Assurance and Improvement meetings with the Medical Directors and Quality Improvement Directors. These quarterly meetings will routinely bring the State and MCO quality teams together, take a population perspective on NH Medicaid program, and, to the greatest degree possible, harmonize of quality initiatives across the NH Medicaid program.

EQRO Technical Review and Report
The State's EQRO Technical Report will include an assessment of each MCOs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries, recommendations for improving the quality of health care services furnished by each MCO, comparative information about all of the State's MCOs, and an assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year, after the first year of NH Medicaid Care Management program operations. This information will be used to inform any needed benefit changes, NH Medicaid Care Management Contract amendments, additional MCO quality improvement activities, sanctions or other program changes. Additionally, the EQRO report will be used to inform the State of any needed oversight or regulatory support to improve managed care health care delivery.

B. And C. Proposed Progress Toward Meeting Quality Objectives
The State will routinely perform the following mandatory quality assurance activities:

- Quality Indicators monitoring, through NH Medicaid Quality Indicators (Appendix B);
- MCO Quality Planning and Operations, through the MCO Quality Assessment and Performance Improvement plans;
- Quality Projects, including the PIP, QIP, and Payment Reform projects;
- External organization reviews, through NCQA accreditation review, including HEDIS and CAHPS results and the EQRO activities and Technical Report;
- Standardized routine reporting, through required MCO operations and other contractual reports (Appendix E, and the NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems Population-based and ad hoc analysis;
- MCO NCQA accreditation review; and
- External Quality Review Organization (EQRO) Reports.

The results of these assessments will inform any improvements or changes needed to ensure high quality health care delivery and optimize Medicaid beneficiary health outcomes.

IV. Review of Quality Strategy

A. Public Input
The initial quality strategy was designed prior to implementation of the Medicaid Care Management program. During that time, the State looked to 42 CFR 438.200, the CMS State Quality Strategy Tool Kit for State Medicaid and Children's Health Insurance Agencies, the quality strategies of other states and DHHS staff to develop an initial draft framework. The State distributed and posted the draft quality strategy and modified the strategy in response to public

comments, stakeholder feedback and the Medicaid Care Management contract Amendment One. The State submitted and received CMS approval for the NH Medicaid Care Management Quality Strategy in May 2014.

Since the implementation of the NH Medicaid Care Management program, each MCO has implemented advisory committees composed of representatives from the provider community (primary care and specialty care), members, family caregivers of MCO members, the advocacy community, and MCO staff. These committees provide a forum for beneficiaries and providers to be actively engaged in MCO quality improvements, raise issues and concerns, discuss possible solutions, and provide advice and recommendations on a wide range of issues. Additionally, the State's EQRO will semi-annually conduct formal focus group discussions to elicit beneficiary feedback without the presence of either DHHS or MCO representatives. The first focus group met in May of 2014 with the results of the report to be released summer 2014.

The State conducts Quality Assurance and Improvement meetings with the Medical Directors and Quality Improvement Directors shortly after implementation. These quarterly meetings routinely bring the State and MCO quality teams together, take a population perspective on NH Medicaid program, and, to the greatest degree possible, harmonize quality initiatives across the NH Medicaid program.

In addition to input from these committees, the quality strategy and supporting reports and documents will be placed on the DHHS NH Medicaid Care Management website at: http://www.dhhs.nh.gov/ocom/care-management.htm and be available for ongoing public review and comment.

B. Strategy Assessment Timeline

Triennially, NH DHHS will comprehensively assess the Quality Strategy, MMIS Reporting Repository database, the MCO Annual Report, the NCQA accreditation process, HEDIS and CAHPS surveys, and other data collected by NH Medicaid such as the Comprehensive Healthcare Information System database (all payer claims database, managed by NH DHHS), the findings from the EQRO Technical Report Evaluation of Improvement Initiatives and the Strengths and Opportunities for Improvement NH Medicaid Care Management Contract Sections.

Timeline for Quality Strategy for the NH Medicaid Managed Care Program – Assessment of Objectives

Quality Strategy Activity	Date Complete
Post Draft Quality Strategy for Step One for Public Comment	July 15, 2012
Post Final Quality Strategy	October 1, 2013
Monitor Quality Performance Results	Continuously
Post Draft of Quality Strategy for Step Three for Public Comments	July 15, 2014
Post Final Quality Strategy	September 1, 2014
Post Draft Quality Strategy for Step Two for	60 days prior to implementation

Public Comment	
Post Final Updated Quality Strategy	30 days prior to implementation
Monitor Quality Performance Results	Continuously
Post Triennial Update Draft Quality Strategy for Public Comment	60 days prior to Agreement Year
Post Final Updated Quality Strategy	30 days prior to Agreement Year
Monitor Quality Performance Results	Continuously

V. Achievements and Opportunities

The most up to date achievements in quality improvement will be presented on the NH Medicaid Quality Indicators website, but will also be included in each MCO's annual report and the EQRO annual Technical Report; both of these reports will be accessible from the NH Medicaid Care Management website and/or the Medicaid Quality Indicators website. Additional program successes will be shared with the Department Public Information Office. Every three years, at a minimum, the Quality Strategy will be formally reviewed and amended to reflect and retain programmatic successes and to address new or unmet quality improvement opportunities.

Appendix A: NH Medicaid Care Management Program Covered Populations and Services Matrix

The planned three-step phase-in of population groups and service is depicted in the Tables below.

Members	Step 1	Step 2	Step 3	Excluded/ FFS
OAA/ANB/APTD/MEAD/TANF/Poverty Level - Non-Duals[2]	X			
Foster Care - With Member Opt Out	X			
Foster Care - Mandatory Enrollment (w/CMS waiver)		X		
HC-CSD (Katie Becket) - With Member Opt Out	X			
CHIP (transition to Medicaid expansion)	X			
TPL (non-Medicare) except members with VA benefits	X			
Auto eligible and assigned newborns	X			
Breast and Cervical Cancer Program (BCCP)	X			
Medicare Duals - With Member Opt Out	X			
Medicare Duals - Mandatory Enrollment (w/CMS waiver)		X		
NHHPP (ACA Expansion Group)			X	
Members with VA Benefits				X
Family Planning Only Benefit (in development)				X
Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns)				X
Spend-down				X
QMB/SLMB Only (no Medicaid)				X

[2] Per 42 USC §1396u-2(a)(2)(A)Non-dual members under age 19 receiving SSI, or with special healthcare needs, or who receive adoption assistance or are in out of home placements, have member opt out.

Services	Step 1	Step 2	NHHPP	Excluded/ FFS
Maternity & Newborn Kick Payments	X			
Inpatient Hospital	X			
Outpatient Hospital3	X			
Inpatient Psychiatric Facility Services Under Age 22	X			
Physicians Services	X			
Advanced Practice Registered Nurse	X			
Rural Health Clinic & FQHC	X			
Prescribed Drugs	X			
Community Mental Health Center Services	X			
Psychology	X			
Ambulatory Surgical Center	X			
Laboratory (Pathology)	X			
X-Ray Services	X			
Family Planning Services	X			
Medical Services Clinic (mostly methadone clinic)	X			
Physical Therapy	X			
Occupational Therapy	X			
Speech Therapy	X			
Audiology Services	X			
Podiatrist Services	X			
Home Health Services	X			
Private Duty Nursing	X			
Adult Medical Day Care	X			

[3] Including facility and ancillary services for dental procedures

Services	Step 1	Step 2	NHHPP	Excluded/ FFS
Personal Care Services	X			
Hospice	X			
Optometric Services Eyeglasses	X			
Furnished Medical Supplies & Durable Medical Equipment	X			
Non-Emergent Medical Transportation (current admin. expense)	X			
Ambulance Service	X			
Wheelchair Van	X			
Independent Case Management	x			
Home Visiting Services	x			
Acquired Brain Disorder Waiver Services		X		
Developmentally Disabled Waiver Services		X		
Choices for Independence Waiver Services		X		
In Home Supports Waiver Services		X		
Skilled Nursing Facility		X		
Skilled Nursing Facility Atypical Care		X		
Inpatient Hospital Swing Beds, SNF		X		
Intermediate Care Facility Nursing Home		X		
Intermediate Care Facility Atypical Care		X		
Inpatient Hospital Swing Beds, ICF		X		
Glencliff Home		X		
Developmental Services Early Supports and Services		X		
New Substance Abuse Benefit Allowing MLDACs		X		
Home Based Therapy – DCYF		X		
Child Health Support Service – DCYF		X		

Services	Step 1	Step 2	NHHPP	Excluded/ FFS
Intensive Home and Community Services – DCYF		X		
Placement Services – DCYF		X		
Private Non-Medical Institutional For Children – DCYF		X		
Crisis Intervention – DCYF		X		
Substance use disorder services as per He-W 513 (NHHPP population only)			X	
Chiropractic services (NHHPP population only)			X	
Intermediate Care Facility MR				X
Medicaid to Schools Services				X
Dental Benefit Services[4]				X

[4] except facility and ancillary services for dental procedures

Appendix B: Medicaid Quality Indicators

Data detail as presented in the NH Medicaid Care Management Contract and as referenced. *Last Updated 6.24.14. Consult with the Department for any recent updates prior to use.*

NH Medicaid Care Management Quality and Oversight Information

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
ACCESSREQ.01	A-F	Member Requests for Assistance Accessing MCO Designated Primary Care Providers by Geographic Region	2 months after the end of the quarter	N/A
ACCESSREQ.02	A-F	Member Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated Primary Care) Providers by Geographic Region	2 months after the end of the quarter	N/A
ACCESSREQ.03	A-F	Member Requests for Assistance Accessing Other Providers (non-Physician/APRN) by Geographic Region	2 months after the end of the quarter	N/A
AMBCARE.01	A-H	Ambulatory Care: Physician/APRN/Clinic Visits by Age Group	4 months after the end of the calendar quarter	<12 months, 12-24 months, 25 months-6 years, 7-11 years, 12-19 years, 20-44, 45-64, >=65
AMBCARE.02	A-C	Ambulatory Care: Physician/APRN/Clinic Visits by Geographic Region	4 months after the end of the calendar quarter	N/A
AMBCARE.03	A-F	Ambulatory Care: Physician/APRN/Clinic Visits by Eligibility Group	4 months after the end of the calendar quarter	N/A
AMBCARE.04	A-H	Ambulatory Care: Emergency Department Visits by Age Group	4 months after the end of the calendar quarter	<12 months, 12-24 months, 25 months-6 years, 7-11 years, 12-19 years, 20-44, 45-64, >=65
AMBCARE.05	A-C	Ambulatory Care: Emergency Department Visits by Geographic Region	4 months after the end of the calendar quarter	N/A
AMBCARE.06	A-F	Ambulatory Care: Emergency Department Visits by Eligibility Group	4 months after the end of the calendar quarter	N/A
AMBCARE.07	A-H	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care by Age Group	4 months after the end of the calendar quarter	<12 months, 12-24 months, 25 months-6 years, 7-11 years, 12-19 years, 20-44, 45-64, >=65

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
AMBCARE.08	A-C	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care by Geographic Region	4 months after the end of the calendar quarter	N/A
AMBCARE.09	A-F	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care by Eligibility Group	4 months after the end of the calendar quarter	N/A
AMBCARE.10	A-C	Annual Access to (use of) Preventive/Ambulatory Health Services, Children by Geographic Region	June 30th	<20
AMBCARE.11	A-C	Annual Access to (use of) Preventive/Ambulatory Health Services, Adults by Geographic Region	June 30th	>=20
APPEALS.01	N/A	Resolution of Standard Appeals Within 30 Calendar Days	30 days after the end of the month	N/A
APPEALS.02	N/A	Resolution of Extended Standard Appeals Within 44 Calendar Days	30 days after the end of the month	N/A
APPEALS.03	N/A	Resolution of Expedited Appeals Within 3 Calendar Days	30 days after the end of the month	N/A
APPEALS.04	N/A	Resolution of All Appeals Within 45 Calendar Days	30 days after the end of the month	N/A
APPEALS.05	N/A	Resolution of Appeals by Disposition Type: Member Abandoned Appeal	30 days after the end of the month	N/A
APPEALS.06	N/A	Resolution of Appeals by Disposition Type: Appeal upheld	30 days after the end of the month	N/A
APPEALS.07	N/A	Resolution of Appeals by Disposition Type: Reversed	30 days after the end of the month	N/A
APPEALS.08	N/A	Resolution of Appeals by Disposition Type: Appeal Elevated to State Fair Hearing	30 days after the end of the month	N/A
APPEALS.09	N/A	Appeals by Reason Type: Denial or Limited Authorization	30 days after the end of the month	N/A

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
APPEALS.10	N/A	Appeals by Reason Type: Reduction, Suspension, or Termination of Previously Authorized Service	30 days after the end of the month	N/A
APPEALS.11	N/A	Appeals by Reason Type: Denial of payment	30 days after the end of the month	N/A
APPEALS.12	N/A	Appeals by Reason Type: Failure to provide timely service	30 days after the end of the month	N/A
APPEALS.13	N/A	Appeals by Reason Type: Untimely Service Authorization	30 days after the end of the month	N/A
APPEALS.14	N/A	Appeals by Reason Type: Failure of MCO to Act Within NH DHHS Contract Timeframes	30 days after the end of the month	N/A
APPEALS.15	N/A	Appeals by Reason Type: Other	30 days after the end of the month	N/A
BHCHLDMEDMGT.01	A-B	Percent of continuously enrolled children using behavioral health medications who received a psychiatric consultation for behavioral health medications by whether or not children are receiving foster care services	June 30th	0-18
BOARDCERT.01	N/A	Board Certification - Percent of Family Medicine Physicians	June 30th	N/A
BOARDCERT.02	N/A	Board Certification - Percent of Internal Medicine Physicians	June 30th	N/A
BOARDCERT.03	N/A	Board Certification - Percent of OB/GYNs	June 30th	N/A
BOARDCERT.04	N/A	Board Certification - Percent of Pediatricians	June 30th	N/A
BOARDCERT.05	N/A	Board Certification - Percent of Geriatricians	June 30th	N/A
BOARDCERT.06	N/A	Board Certification - Percent of Other Physician Specialists	June 30th	N/A
CAHPS_A_	A	Adult CAHPS: CAHPS 5.0H Core Survey - Adults	June 30th	>=18

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
CAHPS_A_	B	Adult CAHPS: CAHPS Supplement: Chronic Conditions - In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment? (CC9, Screening Question)	June 30th	>=18
CAHPS_A_	C	Adult CAHPS: CAHPS Supplement: Chronic Conditions - In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan? (CC10)	June 30th	>=18
CAHPS_A_	D	Adult CAHPS: CAHPS Supplement: Chronic Conditions - In the last 6 months, did you have any health problems that needed special therapy, such as physical, occupational, or speech therapy? (CC11, Screening Question)	June 30th	>=18
CAHPS_A_	E	Adult CAHPS: CAHPS Supplement: Chronic Conditions - In the last 6 months, how often was it easy to get the special therapy you needed through your health plan? (CC12)	June 30th	>=18
CAHPS_A_	F	Adult CAHPS: CAHPS Supplement: Chronic Conditions - Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks. In the last 6 months, did you need someone to come into your home to give you home health care or assistance? (CC13, Screening Question)	June 30th	>=18
CAHPS_A_	G	Adult CAHPS: CAHPS Supplement: Chronic Conditions - In the last 6 months, how often was it easy to get home health care or assistance through your health plan? (CC14)	June 30th	>=18
CAHPS_A_	H	Adult CAHPS: CAHPS Supplement: Behavioral Health - In the last 6 months, did you need any treatment or counseling for a personal or family problem? (MH2, Screening Question)	June 30th	>=18

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
CAHPS_A_	I	Adult CAHPS: CAHPS Supplement: Behavioral Health - In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan? (MH3)	June 30th	>=18
CAHPS_A_	J	Adult CAHPS: CAHPS Supplement: Coordination of Care from Other Health Providers - In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (OHP3, Screening Question)	June 30th	>=18
CAHPS_A_	K	Adult CAHPS: CAHPS Supplement: Coordination of Care from Other Health Providers - In the last 6 months, who helped to coordinate your care? (OHP4.)	June 30th	>=18
CAHPS_A_	L	Adult CAHPS: CAHPS Supplement: Coordination of Care from Other Health Providers - How satisfied are you with the help you received to coordinate your care in the last 6 months? (OHP5)	June 30th	>=18
CAHPS_A_	M	Adult CAHPS: CAHPS Supplement: Quality Improvement Customer Service - Were any of the following a reason you did not get the information or help you needed from your health plan's customer service? (CS1)	June 30th	>=18
CAHPS_A_	N	Adult CAHPS: CAHPS Supplement: Quality Improvement Transportation - Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation? (T1, Screening Question)	June 30th	>=18

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
CAHPS_A_	O	Adult CAHPS: CAHPS Supplement: Quality Improvement Transportation - In the last 6 months, when you phoned to get help with transportation from your health plan, how often did you get it? (T2, Screening Question)	June 30th	>=18
CAHPS_C_	A	Child CAHPS: CAHPS 5.0H Core and Children with Chronic Conditions Survey - Children	June 30th	>=18
CAHPS_C_	B	Child CAHPS: CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor? (OHP1, Screening Question)	June 30th	0-17
CAHPS_C_	C	Child CAHPS: CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers? (OHP2)	June 30th	0-17
CAHPS_C_	D	Child CAHPS: CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (OHP3, Screening Question)	June 30th	0-17
CAHPS_C_	E	Child CAHPS: CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, who helped to coordinate your child's care? (OHP4)	June 30th	0-17

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
CAHPS_C_	F	Child CAHPS: CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - How satisfied are you with the help you got to coordinate your child's care in the last 6 months? (OHP5)	June 30th	0-17
CAHPS_C_	G	Child CAHPS: CAHPS Supplement: Quality Improvement Customer Service - Were any of the following a reason you did not get the information or help you needed from customer service at your child's health plan? (CS1) Summary Counts for each of the following: a) You had to call several times before you could speak with someone (Yes/No) b) The information customer service gave you was not correct (Yes/No) c) Customer service did not have the information you needed (Yes/No) d) You waited too long for someone to call you back (Yes/No) e) No one called you back (Yes/No) f) Some other reason (Yes/No) Please specify:_____	June 30th	0-17
CAHPS_C_	H	Child CAHPS: CAHPS Supplement: Transportation - Some health plans help with transportation for your child to get to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your child's health plan to get help with transportation for your child? (T1, Screening Question)	June 30th	0-17

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
CAHPS_C_	I	Child CAHPS: CAHPS Supplement: Transportation - In the last 6 months, when you phoned your child's health plan to get help with transportation, how often did you get it? (T2, Screening Question)	June 30th	0-17
CARETRANS.01	A-C	Care Transition - Transition Record Transmitted to Health Care Professional (CMS Adult Core Set) - Adults	June 30th	18-64, >=65, Total
CLAIM.01	N/A	Timely Professional and Facility Medical Claim Processing	15 calendar days after end of month	N/A
CLAIM.02	N/A	Days Meeting 30-Day Clean Professional and Facility Claim Processing Standard	15 calendar days after end of month	N/A
CLAIM.03	N/A	Days Meeting 60-Day All Professional and Facility Claim Processing Standard	15 calendar days after end of month	N/A
CLAIM.04	N/A	Timely Pharmacy Claim Processing	15 calendar days after end of month	N/A
CLAIM.05	N/A	Claims Quality Assurance: Claims Processing Accuracy	15 calendar days after end of month	N/A
CLAIM.06	N/A	Claims Quality Assurance: Claims Payment Accuracy	15 calendar days after end of month	N/A
CLAIM.07	N/A	Claims Quality Assurance: Claims Financial Accuracy	15 calendar days after end of month	N/A
CLAIM.08	N/A	Interest on Late Paid Claims	15 calendar days after end of month	N/A

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
CLAIM.09	N/A	Timely Professional and Facility Medical Claim Processing: Sixty Days of Receipt	75 calendar days after end of month	N/A
CMS_A_AMM-AD.01	A-B	Antidepressant Medication Management: Effective Acute Phase Treatment (CMS Adult Core Set)	June 30th	18-64, >=65
CMS_A_AMM-AD.02	A-B	Antidepressant Medication Management: Effective Continuation Phase Treatment (CMS Adult Core Set)	June 30th	18-64, >=65
CMS_A_BCS-AD	A-B	Breast Cancer Screening (CMS Adult Core Set)	June 30th	42-64, 65-69
CMS_A_CCS-AD	N/A	Cervical Cancer Screening (CMS Adult Core Set)	June 30th	24 - 64
CMS_A_CDF-AD	A-B	Screening for Clinical Depression and Follow-up Plan by Age Group (CMS Adult Core Set)	June 30th	18-64, >=65
CMS_A_FUH-AD.01	A-B	Follow-Up After Hospitalization for Mental Illness: Within 7 Days of Discharge (CMS Adult Core Set)	June 30th	21 - 64 and >=65
CMS_A_FUH-AD.02	A-B	Follow-Up After Hospitalization for Mental Illness: Within 30 days of Discharge (CMS Adult Core Set)	June 30th	21 - 64 and >=65
CMS_A_HA1C-AD	A-B	Comprehensive Diabetes Care: Hemoglobin A1c Testing (CMS Adult Core Set)	June 30th	18-64, 65-75
CMS_A_INP_PQI01-AD	A-B	Diabetes Short-Term Complications Admission Rate per 100,000 Member Months (CMS Adult Core Set)	June 30th	18-64, >=65
CMS_A_INP_PQI05-AD	A-B	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months (CMS Adult Core Set)	June 30th	40-64, >=65

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
CMS_A_INP_PQI08-AD	A-B	Congestive Heart Failure (CHF) Admission Rate per 100,000 Member Months (CMS Adult Core Set)	June 30th	18-64, >=65
CMS_A_INP_PQI15-AD	N/A	Asthma in Younger Adults Admission Rate per 100,000 Member Months - Adults (CMS Adult Core Set)	June 30th	Age 18 - 39
CMS_A_INPREADMIT.01	A-B	Plan All-Cause Rate of Readmissions Within 30 Days (CMS Adult Core Set) - Adults	June 30th	18-64, >=65
CMS_A_LDL-AD	A-B	Comprehensive Diabetes Care: LDL-C Screening (CMS Adult Core Set)	June 30th	18-64, 65-75
CMS_A_MPM-AD.01	A-B	Set Annual Monitoring for Members on Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARB) (CMS Adult Core Set)	June 30th	18-64, >=65
CMS_A_MPM-AD.02	A-B	Annual Monitoring for Members on Digoxin (CMS Adult Core Set)	June 30th	18-64, >=65
CMS_A_MPM-AD.03	A-B	Annual Monitoring for Members on Diuretic (CMS Adult Core Set)	June 30th	18-64, >=65
CMS_A_MPM-AD.04	A-B	Annual Monitoring for Members on Anticonvulsants (CMS Adult Core Set)	June 30th	18-64, >=65
CMS_A_MPM-AD.05	A-B	Annual Monitoring for Patients on Persistent Medications (Total) (CMS Adult Core Set)	June 30th	18-64, >=65
CMS_A_PC01-AD	N/A	Elective Delivery (CMS Adult Core Set)	June 30th	N/A
CMS_A_PC03-AD	N/A	Appropriate Use of Antenatal Steroids (CMS Adult Core Set)	June 30th	N/A
CMS_A_PPC-AD	N/A	Prenatal and Postpartum Care: Postpartum Care Rate (CMS Adult Core Set)	June 30th	N/A
CMS_C_BHRA	N/A	Behavioral Health Risk Assessment for Pregnant Women (CMS Adult Core Set)	December 31st	N/A
CMS_C_DEV	A-D	Developmental Screening in the First Three Years of Life (CMS Child Core Set)	June 30th	1, 2, 3, Total

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
DEMGPROF.01	A-F	Community Demographic, Cultural, and Epidemiologic Profile: Preferred Spoken Language	September 30	N/A
DEMGPROF.02	A-F	Community Demographic, Cultural, and Epidemiologic Profile: Preferred Written Language	September 30	N/A
DEMGPROF.03	A-C	Community Demographic, Cultural, and Epidemiologic Profile: Ethnicity	September 30	N/A
DEMGPROF.04	A-G	Community Demographic, Cultural, and Epidemiologic Profile: Race	September 30	N/A
EPSDT.01	N/A	EPSDT performance via Form-CMS 416 procedures: Total Individuals Eligible for EPSDT (Line 1a) including NHHPP members covered by EPSDT.	March 18th of the next Federal FY (April 1 is the due date for CMS)	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20
EPSDT.02	N/A	EPSDT performance via Form-CMS 416 procedures: Total Individuals Eligible for EPSDT for 90 Continuous Days (Line 1b) including NHHPP members covered by EPSDT.	March 18th of the next Federal FY (April 1 is the due date for CMS)	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20
EPSDT.03	N/A	EPSDT performance via Form-CMS 416 procedures: Total Individuals Eligible for EPSDT under a CHIP Medicaid Expansion (Line 1c) including NHHPP members covered by EPSDT.	March 18th of the next Federal FY (April 1 is the due date for CMS)	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20
EPSDT.04	N/A	EPSDT performance via Form-CMS 416 procedures: Total Months of Eligibility (Line 3a) including NHHPP members covered by EPSDT.	March 18th of the next Federal FY (April 1 is the due date for CMS)	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
EPSDT.05	N/A	EPSDT performance via Form-CMS 416 procedures: Total Screens Received (Line 6) including NHHPP members covered by EPSDT.	March 18th of the next Federal FY (April 1 is the due date for CMS)	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20
EPSDT.06	N/A	EPSDT performance via Form-CMS 416 procedures: Total eligible received at least one initial or periodic Screen (Line 9) including NHHPP members covered by EPSDT.	March 18th of the next Federal FY (April 1 is the due date for CMS)	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20
EPSDT.07	N/A	EPSDT performance via Form-CMS 416 procedures: Total Eligibles referred to corrective treatment with the screening provider or referred to another provider for further needed diagnostic or treatment services. (Line 11) including NHHPP members covered by EPSDT.	March 18th of the next Federal FY (April 1 is the due date for CMS)	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20
EPSDT.15	N/A	EPSDT performance via Form-CMS 416 procedures: Total Eligibles enrolled in Managed Care (Line 13) including NHHPP members covered by EPSDT.	March 18th of the next Federal FY (April 1 is the due date for CMS)	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20
EPSDT.16	N/A	EPSDT performance via Form-CMS 416 procedures: Total number of Screening Blood Lead ~~Tests~~ (Tests (Line 14) including NHHPP members covered by EPSDT.	March 18th of the next Federal FY (April 1 is the due date for CMS)	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20
GRIEVANCE.01	N/A	Grievance Dispositions Made Within 45 Calendar Days	30 days after the end of the month	N/A
HEDIS_AAB	N/A	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	June 30th	18-64
HEDIS_AAP	A-F	Annual Access to (use of) Preventive/Ambulatory Health Services- Adults by Age Group	June 30th	20-44, 45-64, >=65

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HEDIS_ADD.01	N/A	Follow Up Care for Children Prescribed ADHD Medication - Initiation	June 30th	6-12
HEDIS_ADD.02	N/A	Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	June 30th	6-12
HEDIS_AMB-1a	A-R	Outpatient and Emergency Dept. Visits/1000 Member Months - Total Population	June 30th	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total
HEDIS_AMB-1b	A-R	Outpatient and Emergency Dept. Visits/1000 Member Months - Medicaid/Medicare Dual-Eligibles	June 30th	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total
HEDIS_AMB-1c	A-R	Outpatient and Emergency Dept. Visits/1000 Member Months - Disabled	June 30th	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total
HEDIS_AMB-1d	A-R	Outpatient and Emergency Dept. Visits/1000 Member Months - Other Low Income	June 30th	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total
HEDIS_AMM.01	N/A	Antidepressant Medication Management - Effective Continuation Phase Treatment - Adults	June 30th	

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HEDIS_AMM.02	A-B	Antidepressant Medication Management - Effective Acute Phase Treatment - Adults	June 30th	
HEDIS_ASM	A-D	Use of Appropriate Medications for People with Asthma - Age 5 to 64	June 30th	5-11, 12-18, 19-50, 51-64
HEDIS_AWC	A	Adolescent Well Care Visits	June 30th	12-21
HEDIS_AWC	B	Adolescent Well Care Visits - Metropolitan Counties	June 30th	12-21
HEDIS_AWC	C	Adolescent Well Care Visits - Non-Metropolitan Counties	June 30th	12-21
HEDIS_BAA	A-C	Adult BMI Assessment	June 30th	18-64, 64-74, Total
HEDIS_BCS	A-C	Breast Cancer Screening - Age 42-69	June 30th	42-64, 65-69, Total
HEDIS_CAP	A	Children and Adolescents' Access To PCP - Age 12 Months - 19 Years	June 30th	12-24 months, 25 months-6 years, 7-11, 12-19, Total
HEDIS_CBP	N/A	Controlling High Blood Pressure - Age 18 to 85	June 30th	
HEDIS_CCS	A	Cervical Cancer Screening - Age 24-64	June 30th	24-64
HEDIS_CDC	N/A	Comprehensive Diabetes Care - HbA1c Control (>9%)	June 30th	18-75
HEDIS_CDC	N/A	Comprehensive Diabetes Care - HbA1c Testing	June 30th	18-64, 65-75, Total
HEDIS_CDC	N/A	Comprehensive Diabetes Care - Medical Attention for Nephropathy	June 30th	18-75
HEDIS_CDC	N/A	Comprehensive Diabetes Care - Eye Exam	June 30th	18-75
HEDIS_CDC.01	N/A	Comprehensive Diabetes Care - HbA1c Testing	June 30th	
HEDIS_CDC.02	N/A	Comprehensive Diabetes Care - LDL-C Screening	June 30th	
HEDIS_CHL	A-C	Chlamydia Screening in Women - Age 16 to 24	June 30th	16-20, 21-24, Total
HEDIS_CIS	A	Childhood Immunization Status - Combo 2	June 30th	2
HEDIS_CIS	B	Childhood Immunization Status - Combo 3	June 30th	2
HEDIS_CIS	C	Childhood Immunization Status - Combo 4	June 30th	2
HEDIS_CIS	D	Childhood Immunization Status - Combo 5	June 30th	2
HEDIS_CIS	E	Childhood Immunization Status - Combo 6	June 30th	2

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HEDIS_CIS	F	Childhood Immunization Status - Combo 7	June 30th	2
HEDIS_CIS	G	Childhood Immunization Status - Combo 8	June 30th	2
HEDIS_CIS	H	Childhood Immunization Status - Combo 9	June 30th	2
HEDIS_CIS	I	Childhood Immunization Status - Combo 10	June 30th	2
HEDIS_CIS	J	Childhood Immunization Status - DTaP	June 30th	2
HEDIS_CIS	K	Childhood Immunization Status - IPV	June 30th	2
HEDIS_CIS	L	Childhood Immunization Status - MMR	June 30th	2
HEDIS_CIS	M	Childhood Immunization Status - HiB	June 30th	2
HEDIS_CIS	N	Childhood Immunization Status - Hepatitis B	June 30th	2
HEDIS_CIS	O	Childhood Immunization Status - VZV	June 30th	2
HEDIS_CIS	P	Childhood Immunization Status - Pneumococcal Conjugate	June 30th	2
HEDIS_CIS	Q	Childhood Immunization Status - Hepatitis A	June 30th	2
HEDIS_CIS	R	Childhood Immunization Status - Rotavirus	June 30th	2
HEDIS_CIS	S	Childhood Immunization Status - Influenza	June 30th	2
HEDIS_CMC	N/A	Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	June 30th	18-75
HEDIS_CWP	N/A	Appropriate Testing for Children With Pharyngitis	June 30th	2-18
HEDIS_FPC	A	Frequency of Ongoing Prenatal Care (<21% of Expected Number of Visits)	June 30th	N/A
HEDIS_FPC	B	Frequency of Ongoing Prenatal Care (21-40% of Expected Number of Visits)	June 30th	N/A
HEDIS_FPC	C	Frequency of Ongoing Prenatal Care (41-60% of Expected Number of Visits)	June 30th	N/A

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HEDIS_FPC	D	Frequency of Ongoing Prenatal Care (61-80% of Expected Number of Visits)	June 30th	N/A
HEDIS_FPC	E	Frequency of Ongoing Prenatal Care (>= 81% of Expected Number of Visits)	June 30th	N/A
HEDIS_FUH.01	A-C	Follow Up After Hospitalization For Mental Illness - 7 days	June 30th	6-20, >=21, Total
HEDIS_FUH.02	A-C	Follow Up After Hospitalization For Mental Illness - 30 days	June 30th	6-20, >=21, Total
HEDIS_HPV	N/A	Human Papillomavirus (HPV) Vaccine for Female Adolescents	June 30th	13
HEDIS_IET.01	A-C	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	June 30th	13-17, 18+, Total
HEDIS_IET.02	A-C	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	June 30th	13-17, 18+, Total
HEDIS_IMA	A	Immunizations for Adolescents - Combination 1	June 30th	13
HEDIS_IMA	B	Immunizations for Adolescents - Meningococcal	June 30th	13
HEDIS_IMA	C	Immunizations for Adolescent - Tdap/Td	June 30th	13
HEDIS_LBP	N/A	Use of Imaging Studies for Low Back Pain	June 30th	N/A
HEDIS_MMA	N/A	Medication Management for People with Asthma - At Least 50% of Treatment Period - Age 5 to 18	June 30th	5-18
HEDIS_MMA	N/A	Medication Management for People with Asthma - At Least 75% of Treatment Period - Age 5 to 18	June 30th	5-18
HEDIS_MPM	A-C	Annual Monitoring for Patients on Persistent Medications - Adults - ACE or ARB	June 30th	18-64, >=65, Total
HEDIS_MPM	A-C	Annual Monitoring for Patients on Persistent Medications - Adults - Anticonvulsants	June 30th	18-64, >=65, Total

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HEDIS_MPM	A-C	Annual Monitoring for Patients on Persistent Medications - Adults - Digoxin	June 30th	18-64, >=65, Total
HEDIS_MPM	A-C	Annual Monitoring for Patients on Persistent Medications - Adults - Total Rate	June 30th	18-64, >=65, Total
HEDIS_MPM	A-C	Annual Monitoring for Patients on Persistent Medications - Adults - Diuretics	June 30th	18-64, >=65, Total
HEDIS_PPC	A	Prenatal and Postpartum Care - Postpartum Care - Total	June 30th	N/A
HEDIS_PPC	N/A	Prenatal and Postpartum Care - Timeliness of Prenatal Care	June 30th	N/A
HEDIS_SAA	A	Adherence to Antipsychotics for Individuals with Schizophrenia - Adults Age 19-64	June 30th	19-64
HEDIS_SPR	N/A	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	June 30th	>=40
HEDIS_URI	N/A	Appropriate Treatment for Children With Upper Respiratory Infection	June 30th	3 months-18 years old
HEDIS_W15	A	Well-Child Visits in the first 15 Months of Life (0 visit)	June 30th	15 months
HEDIS_W15	B	Well-Child Visits in the first 15 Months of Life (1 visit)	June 30th	15 months
HEDIS_W15	C	Well-Child Visits in the first 15 Months of Life (2 visits)	June 30th	15 months
HEDIS_W15	D	Well-Child Visits in the first 15 Months of Life (3 visits)	June 30th	15 months
HEDIS_W15	E	Well-Child Visits in the first 15 Months of Life (4 visits)	June 30th	15 months
HEDIS_W15	F	Well-Child Visits in the first 15 Months of Life (5 visits)	June 30th	15 months
HEDIS_W15	G	Well-Child Visits in the first 15 Months of Life (6 or more visits) - Total	June 30th	15 months
HEDIS_W15	H	Well-Child Visits in the first 15 Months of Life (6 or more visits) - Metropolitan Counties	June 30th	15 months

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HEDIS_W15	I	Well-Child Visits in the first 15 Months of Life (6 or more visits) - Non-Metropolitan Counties	June 30th	15 months
HEDIS_W34	A	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Total Population	June 30th	3-6
HEDIS_W34	B	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Metropolitan Counties	June 30th	3-6
HEDIS_W34	C	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Non-Metropolitan Counties	June 30th	3-6
HEDIS_WCC	A-C	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	June 30th	3-11, 12-17, Total
HEDIS_WCC	A-C	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile documentation	June 30th	3-11, 12-17, Total
HEDIS_WCC	A-C	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	June 30th	3-11, 12-17, Total
HPP_ACCESSREQ.01	A-F	Member Requests for Assistance Accessing MCO Designated Primary Care Providers by Geographic Region - NHHPP Members	2 months after the end of the quarter	N/A
HPP_ACCESSREQ.02	A-F	Member Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated Primary Care) Providers by Geographic Region - NHHPP Members	2 months after the end of the quarter	N/A
HPP_ACCESSREQ.03	A-F	Member Requests for Assistance Accessing Other Providers (non-Physician/APRN) by Geographic Region - NHHPP Members	2 months after the end of the quarter	N/A
HPP_AMBCARE.01	A-B	Ambulatory Care: Physician/APRN/Clinic Visits by Age Group - NHHPP Members	4 months after the end of the calendar quarter	19-44, 45-64

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HPP_AMBCARE.02	A-C	Ambulatory Care: Physician/APRN/Clinic Visits by Geographic Region - NHHPP Members	4 months after the end of the calendar quarter	N/A
HPP_AMBCARE.04	A-B	Ambulatory Care: Emergency Department Visits by Age Group - NHHPP Members	4 months after the end of the calendar quarter	19-44, 45-64
HPP_AMBCARE.05	A-C	Ambulatory Care: Emergency Department Visits by Geographic Region - NHHPP Members	4 months after the end of the calendar quarter	N/A
HPP_AMBCARE.07	A-B	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care by Age Group - NHHPP Members	4 months after the end of the calendar quarter	19-44, 45-64
HPP_AMBCARE.08	A-C	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care by Geographic Region - NHHPP Members	4 months after the end of the calendar quarter	N/A
HPP_AMBCARE.11	A-C	Annual Access to (use of) Preventive/Ambulatory Health Services, Adults by Geographic Region - NHHPP Members	June 30th	>=20
HPP_CMS_A_FUH-AD.01	A-B	Follow-Up After Hospitalization for Mental Illness: Within 7 days of Discharge (CMS Adult Core Set) - NHHPP Members	June 30th	21 - 64 and >=65
HPP_CMS_A_FUH-AD.02	A-B	Follow-Up After Hospitalization for Mental Illness: Within 30 Days of Discharge (CMS Adult Core Set) - NHHPP Members	June 30th	21 - 64 and >=65
HPP_CMS_A_HA1C-AD	A-B	Comprehensive Diabetes Care: Hemoglobin A1c Testing (CMS Adult Core Set) - NHHPP Members	June 30th	18-64, 65-75
HPP_CMS_A_INP_PQI01-AD	A-B	Diabetes Short-Term Complications Admission Rate per 100,000 Member Months - Adults (CMS Adult Core Set) - NHHPP Members	June 30th	18-64, >=65

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HPP_CMS_A_INP_PQI05-AD	A-B	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months - Adults (CMS Adult Core Set) - NHHPP Members	June 30th	40-64, >=65
HPP_CMS_A_INP_PQI08-AD	A-B	Congestive Heart Failure Admission Rate per 100,000 Member Months - Adults (CMS Adult Core Set) - NHHPP Members	June 30th	18-64, >=65
HPP_CMS_A_INP_PQI15-AD		Asthma in Younger Adults Admission Rate per 100,000 Member Months - Adults (CMS Adult Core Set) - NHHPP Members	June 30th	Age 18 - 39
HPP_CMS_A_LDL-AD	A-B	Comprehensive Diabetes Care: LDL-C Screening (CMS Adult Core Set) - NHHPP Members	June 30th	18-64, 65-75
HPP_HEDIS_AAP	A-F	Annual Access to (use of) Preventive/Ambulatory Health Services- Adults by Age Group - NHHPP Members	June 30th	20-44, 45-64, >=65
HPP_HEDIS_AMB-1d	A-R	Outpatient and Emergency Dept. Visits/1000 Member Months - NHHPP Members	June 30th	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total
HPP_HEDIS_CDC.01	N/A	Comprehensive Diabetes Care - HbA1c Testing - NHHPP Members	June 30th	
HPP_HEDIS_CDC.02	N/A	Comprehensive Diabetes Care - LDL-C Screening - NHHPP Members	June 30th	
HPP_HEDIS_CDC.03	N/A	Comprehensive Diabetes Care - Eye Exam - NHHPP Members	June 30th	
HPP_HEDIS_CDC.04	N/A	Comprehensive Diabetes Care - Medical Attention for Nephropathy - NHHPP Members	June 30th	
HPP_HEDIS_FUH.01	N/A	Follow Up After Hospitalization For Mental Illness - 7 days - NHHPP Members	June 30th	

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HPP_HEDIS_FUH.02	N/A	Follow Up After Hospitalization For Mental Illness - 30 days - NHHPP Members	June 30th	
HPP_HRA.01	N/A	Health Risk Assessment Quarterly Completions, With Subreport for NHHPP Members	Last day of the month following quarter	N/A
HPP_HRA.02	N/A	Health Risk Assessment Completion Percentage, With Subreport for NHHPP Members	Last day of the month following quarter	N/A
HPP_HRA.03	N/A	Health Risk Assessment Completion for Higher Risk Populations, With Subreport for NHHPP Members	Last day of the month following quarter	N/A
HPP_INPASC.01	N/A	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members - Quarterly Rate - NHHPP Members	4 months after the end of the quarter	N/A
HPP_INPASC.02	A-B	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members- Annual Rate by Age Group - NHHPP Members	June 30th	18-44, 45-64
HPP_INPREADMIT.01	N/A	Plan All-Cause Rate of Readmissions Within 30 Days (CMS Adult Core Set) - Adults - NHHPP Members	June 30th	
HPP_MEMCOMM.08	N/A	Member Communications: New Member Welcome Calls - NHHPP Members	15 days after the end of reporting period	N/A
HPP_NEMT.01	N/A	NEMT Request Authorization and Delivery Rate: Non-wheelchair Van - NHHPP Members	1 month after the end of reporting period	N/A
HPP_NEMT.02	N/A	NEMT Request Authorization and Delivery Rate: Wheelchair Van - NHHPP Members	1 month after the end of reporting period	N/A

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HPP_NEMT.03	A-F	NEMT Requests Delivered by Mode of Transportation - NHHPP Members	1 month after the end of reporting period	N/A
HPP_NEMT.04	A-G	NEMT Services Delivered by Type of Medical Service: In-State Providers - NHHPP Members	1 month after the end of reporting period	N/A
HPP_NEMT.05	A-G	NEMT Services Delivered by Type of Medical Service: Out-of-State Providers - NHHPP Members	1 month after the end of reporting period	N/A
HPP_NHHDISCHARGE.01	N/A	New Hampshire Hospital Discharges With Discharge Plan - NHHPP Members	Within 30 days of the end of the quarter	N/A
HPP_NHHDISCHARGE.02	N/A	New Hampshire Hospital Discharges Where Member Was Contacted Within 3 Calendar Days of Discharge - NHHPP Members	Within 30 days of the end of the quarter	N/A
HPP_NHHDISCHARGE.03	N/A	New Hampshire Hospital Discharges Where Patient Had Follow up Appointment Within 7 Calendar Days of Discharge - NHHPP Members	Within 30 days of the end of the quarter	N/A
HPP_NHHREADMIT.02	N/A	Readmission to NH Hospital at 30 days - NHHPP Members	September 1st	N/A
HPP_NHHREADMIT.03	N/A	Readmission to NH Hospital at 180 days - NHHPP Members	September 1st	N/A
HPP_PHARMPAY.01	A-B	Mean Pharmacy Payments per Member per Month by Age Group - NHHPP Members	2 months after the end of the quarter	19-44, 45-64

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HPP_PHARMPAY.03	A-B	Median Pharmacy Payments per Member per Month by Age Group - NHHPP Members	2 months after the end of the quarter	19-44, 45-64
HPP_PHARMPAY.05	A-C	Total Monthly Pharmacy Payment Amount - NHHPP Members	2 months after the end of the quarter	N/A
HPP_PHARMUTIL.01	A-B	Pharmacy Prescriptions Filled per Member per Month by Age Group	2 months after the end of the quarter	19-44, 45-64
HPP_POLYPHARM.01	A-J	Polypharmacy Monitoring for All Medications by Age Group - NHHPP Members	2 months after the end of the quarter	19-44, 45-64
HPP_SUD.01	A-B	Substance Use Disorder Services: Overall Rate of Users of Any SUD Service in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.02	A-B	Substance Use Disorder Services: Rate of Users of Outpatient Non-Facility Individual, Family, or Group SUD Counseling Service in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.03	A-B	Substance Use Disorder Services: Rate of Use of Outpatient Non-Facility Individual, Family, or Group SUD Counseling Service in NHHPP Population Using Specific Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.04	A-B	Substance Use Disorder Services: Rate of Use of Outpatient Non-Facility Individual, Family, or Group SUD Counseling Service in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.05	A-B	Substance Use Disorder Services: Rate of Users of Medically Monitored Withdrawal Service in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.06	A-B	Substance Use Disorder Services: Rate of Use of Medically Monitored Withdrawal Service in NHHPP Population Using Specific Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.07	A-B	Substance Use Disorder Services: Rate of Use of Medically Monitored Withdrawal Service in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HPP_SUD.08	A-B	Substance Use Disorder Services: Rate of Users of Opioid Treatment Center Service in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.09	A-B	Substance Use Disorder Services: Rate of Use of Opioid Treatment Center Service in NHHPP Population Using Specific Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.10	A-B	Substance Use Disorder Services: Rate of Use of Opioid Treatment Center Service in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.11	A-B	Substance Use Disorder Services: Rate of Users of Buprenorphine in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.12	A-B	Substance Use Disorder Services: Rate of Use of Buprenorphine in NHHPP Population Using Specific Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.13	A-B	Substance Use Disorder Services: Rate of Use of Buprenorphine in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.14	A-B	Substance Use Disorder Services: Rate of Users of Partial Hospitalization for SUD in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.15	A-B	Substance Use Disorder Services: Rate of Use of Partial Hospitalization for SUD in NHHPP Population Using Specific Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.16	A-B	Substance Use Disorder Services: Rate of Use of Partial Hospitalization for SUD in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.17	A-B	Substance Use Disorder Services: Rate of Users of Intensive Outpatient Treatment for SUD in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HPP_SUD.18	A-B	Substance Use Disorder Services: Rate of Use of Intensive Outpatient Treatment for SUD in NHHPP Population Using Specific Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.19	A-B	Substance Use Disorder Services: Rate of Use of Intensive Outpatient Treatment for SUD in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.20	A-B	Substance Use Disorder Services: Rate of Users of General Acute Care Inpatient Hospital Withdrawal Service in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.21	A-B	Substance Use Disorder Services: Rate of Use of General Acute Care Inpatient Hospital Withdrawal Service in NHHPP Population Using Specific Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.22	A-B	Substance Use Disorder Services: Rate of Use of General Acute Care Inpatient Hospital Withdrawal Service in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.23	A-B	Substance Use Disorder Services: Rate of Users of SUD Rehabilitation Facility Service in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.24	A-B	Substance Use Disorder Services: Rate of Use of SUD Rehabilitation Facility Service in NHHPP Population Using Specific Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.25	A-B	Substance Use Disorder Services: Rate of Use of SUD Rehabilitation Facility Service in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.26	A-B	Substance Use Disorder Services: Rate of Users of Mobile Crisis Intervention Service for SUD in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HPP_SUD.27	A-B	Substance Use Disorder Services: Rate of Use of Mobile Crisis Intervention Service for SUD in NHHPP Population Using Specific Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.28	A-B	Substance Use Disorder Services: Rate of Use of Mobile Crisis Intervention Service for SUD in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.29	A-B	Substance Use Disorder Services: Rate of Users of Office Based Crisis Intervention Service for SUD in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.30	A-B	Substance Use Disorder Services: Rate of Use of Office Based Crisis Intervention Service for SUD in NHHPP Population Using Specific Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.31	A-B	Substance Use Disorder Services: Rate of Use of Office Based Crisis Intervention Service for SUD in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.32	A-B	Substance Use Disorder ED Use: Rate of ED Use for Substance Abuse Disorder Diagnoses Across All Populations (NHHPP & non-NHHPP) by Eligibility Group	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.33	A-B	Substance Use Disorder ED Use: Rate of ED Use for Substance Abuse Disorder Diagnoses in NHHPP Population	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.34	A-B	Substance Use Disorder ED Use: Rate of ED Use for Substance Abuse Disorder Diagnoses in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64
HPP_SUD.35	A-B	Substance Use Disorder ED Use: Rate of ED Use for Any Diagnosis in NHHPP Population Using Any SUD Service	4 months after the end of the calendar quarter	19-34, 35-49, 50-64

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
HPP_SUD.36	A-B	Follow Up After SUD Rehabilitation Facility Stay - 7 days	June 30th	19-34, 35-49, 50-64
HPP_SUD.37	A-B	Follow Up After SUD Rehabilitation Facility Stay - 30 days	June 30th	19-34, 35-49, 50-64
HPP_SUD.41	A-C	Member to Provider Ratio by Geographic Region: Substance Abuse Counselors - NHHPP Members	2 months after the end of the quarter	N/A
HPP_SUDIET.01	A-B	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - NHHPP Members	June 30th	19-34, 35-49, 50-64
HPP_SUDIET.02	A-B	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - NHHPP Members	June 30th	19-34, 35-49, 50-64
HRA.01	N/A	Health Risk Assessment Quarterly Completions	Last day of the month following quarter	N/A
HRA.02	N/A	Health Risk Assessment Completion Percentage	Last day of the month following quarter	N/A
HRA.03	N/A	Health Risk Assessment Completion for Higher Risk Populations	Last day of the month following quarter	N/A
INPASC.01	N/A	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members - Quarterly Rate	4 months after the end of the quarter	N/A
INPASC.02	A-C	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members- Annual Rate by Age Group	June 30th	18-44, 45-64, >=65
MAINTMED.01	A-C	Maintenance Medication Gaps	2 months after the end of the quarter	0-5, 6-18, 19-64

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
MEMCOMM.01	A-F	Member Communications: Speed to Answer Within 30 Seconds	15 days after the end of reporting period	N/A
MEMCOMM.02	A-F	Member Communications: Mean Hold Time	15 days after the end of reporting period	N/A
MEMCOMM.03	A-F	Member Communications: Calls Abandoned	15 days after the end of reporting period	N/A
MEMCOMM.04	A-F	Member Communications: Mean Call Time	15 days after the end of reporting period	N/A
MEMCOMM.05	A-F	Member Communications: Voice Mails Returned by Next Business Day	15 days after the end of reporting period	N/A
MEMCOMM.06	A-K	Member Communications: Reasons for Telephone Inquiries	15 days after the end of reporting period	N/A
MEMCOMM.07	A-D	Member Communications: Warm Transfers to NH DHHS	15 days after the end of reporting period	N/A
MEMCOMM.08	N/A	Member Communications: New Member Welcome Calls	15 days after the end of reporting period	N/A
MEMCOMM.09	N/A	Beneficiary Communications Website - Number of Beneficiary logins to MCO Beneficiary website portal	September 30th	N/A
MEMCOMM.10	N/A	Member Communications Website: Requests for Additional Information	September 30th	N/A

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
NEMT.01	N/A	NEMT Request Authorization and Delivery Rate: Non-wheelchair Van	1 month after the end of reporting period	N/A
NEMT.02	N/A	NEMT Request Authorization and Delivery Rate: Wheelchair Van	1 month after the end of reporting period	N/A
NEMT.03	A-F	NEMT Requests Delivered by Mode of Transportation	1 month after the end of reporting period	N/A
NEMT.04	A-G	NEMT Services Delivered by Type of Medical Service: In-State Providers	1 month after the end of reporting period	N/A
NEMT.05	A-G	NEMT Services Delivered by Type of Medical Service: Out-of-State Providers	1 month after the end of reporting period	N/A
NHHDISCHARGE.01	N/A	New Hampshire Hospital Discharges With Discharge Plan	Within 30 days of the end of the quarter	N/A
NHHDISCHARGE.02	N/A	New Hampshire Hospital Discharges Where Member Was Contacted Within 3 Calendar Days of Discharge	Within 30 days of the end of the quarter	N/A
NHHDISCHARGE.03	N/A	New Hampshire Hospital Discharges Where Patient Had Follow up Appointment Within 7 Calendar Days of Discharge	Within 30 days of the end of the quarter	N/A
NHHREADMIT.02	N/A	Readmission to New Hampshire Hospital at 30 days	September 1st	N/A

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
NHHREADMIT.03	N/A	Readmission to NH Hospital at 180 days	September 1st	N/A
PHARMPAY.01	A-F	Mean Pharmacy Payments per Member per Month by Age Group	2 months after the end of the quarter	<=5, 6-13, 14-18, 19-44, 45-64, >=65
PHARMPAY.02	A-G	Mean Pharmacy Payments Per Member per Month by Eligibility Group	2 months after the end of the quarter	N/A
PHARMPAY.03	A-F	Median Pharmacy Payments per Member per Month by Age Group	2 months after the end of the quarter	<=5, 6-13, 14-18, 19-44, 45-64, >=65
PHARMPAY.04	A-G	Median Pharmacy Payments per Member per Month by Eligibility Group	2 months after the end of the quarter	N/A
PHARMPAY.05	A-C	Total Monthly Pharmacy Payment Amount	2 months after the end of the quarter	N/A
PHARMUTIL.01	A-F	Pharmacy Prescriptions Filled per Member per Month by Age Group	2 months after the end of the quarter	<=5, 6-13, 14-18, 19-44, 45-64, >=65
PHARMUTIL.02	A-G	Pharmacy Prescriptions Filled per Member per Month by Eligibility Group	2 months after the end of the quarter	N/A
PHARMUTLMGT.01	N/A	Pharmacy Utilization Management: Adherence to State PDL	2 months after the end of the quarter	N/A
PHARMUTLMGT.02	N/A	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	2 months after the end of the quarter	N/A
PHARMUTLMGT.03	N/A	Pharmacy Utilization Management: Generic Drug Substitution	2 months after the end of the quarter	N/A
PHARMUTLMGT.04	N/A	Pharmacy Utilization Management: Generic Drug Utilization	2 months after the end of the quarter	N/A

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
POLYPHARM.01	A-R	Polypharmacy Monitoring for All Medications by Age Group	2 months after the end of the quarter	0-18, 19-44, 45-64
POLYPHARM.02	A-R	Polypharmacy Monitoring for Behavioral Health Medications: All Children	2 months after the end of the quarter	0-5, 6-18
POLYPHARM.03	A-R	Polypharmacy Monitoring for Behavioral Health Medications: Children Receiving Foster Care Services	2 months after the end of the quarter	0-5, 6-18, Total 0-18
PROVCOMM.01	A-F	Provider Communications: Speed to Answer Within 30 Seconds	15 days after end of reporting period	N/A
PROVCOMM.02	A-F	Provider Communications: Mean Hold Time	15 days after end of reporting period	N/A
PROVCOMM.03	A-F	Provider Communications: Calls Abandoned	15 days after end of reporting period	N/A
PROVCOMM.04	A-F	Provider Communications: Mean Call Time	15 days after end of reporting period	N/A
PROVCOMM.05	A-F	Provider Communications: Voice Mails Returned by Next Business Day	15 days after end of reporting period	N/A
PROVCOMM.06	A-J	Provider Communications: Reasons for Telephone Inquiries	15 days after end of reporting period	N/A
PROVRATIO.01	A-C	Member to Provider Ratio by Geographic Region: MCO Designated Primary Care Providers	2 months after the end of the quarter	N/A
PROVRATIO.02	A-C	Member to Provider Ratio by Geographic Region: Pediatricians	2 months after the end of the quarter	N/A

Reporting ID	SUB ID	Name	Delivery Date for Measure or Report After Initial Period	Age Groups
PROVRATIO.03	A-C	Member to Provider Ratio by Geographic Region: Maternity Providers	2 months after the end of the quarter	N/A
SERVICEAUTH.01	N/A	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	2 months after the end of the quarter	N/A
SERVICEAUTH.02	N/A	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Continued/Extended Urgent Services	2 months after the end of the quarter	N/A
SERVICEAUTH.03	N/A	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	2 months after the end of the quarter	N/A
SERVICEAUTH.04	N/A	Pharmacy Service Authorization Timely Determination Rate	2 months after the end of the quarter	N/A
TIMELYNOTICE.01	N/A	Timeliness of Notice Delivery: Denial of Payment	2 months after the end of the quarter	N/A
TIMELYNOTICE.02	N/A	Timeliness of Notice Delivery: Standard Service Authorization Denial	2 months after the end of the quarter	N/A
TIMELYNOTICE.03	N/A	Timeliness of Notice Delivery: Standard Service Authorization Denial With Extension	2 months after the end of the quarter	N/A
TIMELYNOTICE.04	N/A	Timeliness of Notice Delivery: Expedited Process	2 months after the end of the quarter	N/A

Appendix C: NH Medicaid Care Management Program Encounter, Member and Provider Data Detail

Data detail as presented in the NH Medicaid Care Management Contract and as referenced. *Last Updated 7.2.12. Consult with the Department for any recent updates prior to use.*

MCO Encounter, Member, and Provider Data Sets Data Elements	Medical Encounter	Pharmacy Encounter	Member
Allowed amount	x	x	
Billed/Charge Amount	x	x	
Billing Provider City Name	x	x	
Billing Provider Country Name	x	x	
Billing Provider Location City Name	x	x	
Billing Provider Location State or Province	x	x	
Billing Provider Location Street Address	x	x	
Billing Provider Location ZIP Code	x	x	
Billing Provider Medicaid ID	x	x	
Billing Provider Name	x	x	
Billing Provider NPI	x	x	
Billing Provider Payer ID	x	x	
Billing Provider Specialty	x	x	
Billing Provider State or Province	x	x	
Billing Provider Street Address	x	x	
Billing Provider Type (e.g., hospital, optometrist)	x	x	
Billing Provider ZIP Code	x	x	
Category/Type of Service (e.g., 'Physician') universal across claim types to be defined in conjunction with DHHS, standard across MCOs)	x	x	
Charge Amount	x	x	
Claim Adjudication Date	x	x	
Claim ID	x	x	

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Claim Line Number	x	x	
Claim Paid Date	x	x	
Claim Transaction Status (e.g., paid, denied)	x	x	
Claim Transaction Type (e.g., adjusted claim, void)	x	x	
Claim Type (e.g., drug, medical)	x	x	
Claim Version	x	x	
Co-pay Amount	x	x	
Date Claim Received	x	x	
Date of Service – From	x	x	
Date of Service – Through	x	x	
Date Service Approved	x	x	
Diagnosis Codes Principal and Other - MCO to Provide All Submitted by Providers	x		
Discharge Date	x		
Dual Medicare Status at Service Date of Claim	x	x	
E-Code	x		
EOB Codes	x		
Facility Type - Professional	x		
Institutional - Admission Date	x		
Institutional - Admission Hour	x		
Institutional - Admission Source	x		
Institutional - Admission Type	x		
Institutional - Admitting Diagnosis	x		
Institutional - Covered Days	x		
Institutional - Days	x		

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Institutional - Discharge Hour	x		
Institutional - Discharge Status	x		
Institutional - Inpatient - Present on Admission Codes for All Diagnosis Codes as Specified by DHHS	x		
Institutional - Inpatient DRG (if DRG payment system is used)	x		
Institutional - Inpatient DRG allowed amount (if DRG payment system is used)	x		
Institutional - Inpatient DRG outlier amount (if DRG payment system is used)	x		
Institutional - Inpatient DRG outlier days (if DRG payment system is used)	x		
Institutional - Inpatient DRG Version (if DRG payment system is used)	x		
Institutional - Inpatient DRG Version (if used)	x		
Institutional - Occurrence Code Values/Dates - MCO to Provide All Submitted by Providers	x		
Institutional - Occurrence Codes - MCO to Provide All Submitted by Providers	x		
Institutional - Revenue Code	x		
Institutional - Type of Bill	x		
Institutional Inpatient Procedure Codes (ICD) - MCO to Provide All Submitted by Providers	x		
Institutional Paid Amount - Detail (where applicable)	x	x	
MCO Assigned Provider ID	x	x	
MCO Group ID Number	x	x	x
MCO ID	x	x	x
MCO Internal Member ID	x	x	x
Medicaid Eligibility Category at Service Date on Claim	x	x	
Medicaid Special Eligibility Category at Service Date on Claim (e.g., nursing home, waiver program)	x	x	

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Medical Claim Drug Codes (e.g., J codes)	x		
Member Address	x	x	x
Member Age at Time of Claim Using Last Date of Service	x	x	
Member Bureau of Behavioral Health Eligibility Status			x
Member City	x	x	x
Member County			x
Member Date of Birth	x	x	x
Member Date of Death			x
Member Dual Medicare Status			x
Member Gender	x	x	x
Member Lock-In Dates			x
Member Lock-In Indicator			x
Member Lock-In Pharmacy/Provider			x
Member Medicaid Eligibility Category			x
Member Medicaid Special Eligibility Category (e.g., nursing home, waiver program)			x
Member Name	x	x	x
Member Rate Cell			x
Member Risk Score/Status			x
Member Risk Status Percentile Rank			x
Member SSN			x
Member State	x	x	x
Member Year and Month			x
Member Zip Code	x	x	x
NH Medicaid Member ID	x	x	x
Outpatient Hospital Payment Group (if used)	x		

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Outpatient Hospital Payment Grouper Used (if used)	x		
Outpatient Hospital Payment Grouper Version (if used)	x		
Paid Amount	x	x	
Pharmacy Basis of Provider Reimbursement on the Paid Claim		x	
Pharmacy Compound Drug Indicator		x	
Pharmacy Days Supply		x	
Pharmacy Dispensed as Written Indicator		x	
Pharmacy Dispensing Fee		x	
Pharmacy Drug Name		x	
Pharmacy Drug NDC		x	
Pharmacy Fill Number		x	
Pharmacy Generic Drug Indicator		x	
Pharmacy Ingredient Cost		x	
Pharmacy Location City Name		x	
Pharmacy Location State or Province		x	
Pharmacy Location ZIP Code		x	
Pharmacy Metric Units		x	
Pharmacy Name		x	
Pharmacy NH Medicaid Pharmacy Provider ID		x	
Pharmacy Postage Amount		x	
Pharmacy Prescribing Provider DEA Number		x	
Pharmacy Prescribing Provider MCO ID		x	
Pharmacy Prescribing Provider NPI		x	
Pharmacy Prescription Number		x	
Pharmacy Tax ID		x	

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Place of Service	x	x	
Prepaid Amount/Fee Schedule Equivalent (if provider being paid on capitated basis)	x	x	
Primary Care Provider Assigned From Date			x
Primary Care Provider Assigned To Date			x
Primary Care Provider Clinic/Business Name			x
Primary Care Provider Location City Name			x
Primary Care Provider Location State or Province			x
Primary Care Provider Location Street address			x
Primary Care Provider Location ZIP Code			x
Primary Care Provider Medicaid ID			x
Primary Care Provider Name			x
Primary Care Provider NPI			x
Primary Care Provider Payer ID			x
Primary Care Provider Specialty			x
Primary Care Provider Tax ID			x
Primary Care Provider Type (e.g., Physician, APRN)			x
Prior Authorization Number	x	x	
Procedure Codes (HCPCS/CPT) - MCO to Provide All Submitted by Providers as Specified by DHHS	x		
Procedure Modifier Codes and Description – MCO to Provide All Submitted by Providers as Specified by DHHS	x		
Quantity/Units Billed	x		
Quantity/Units Paid	x		
Referring Provider Name	x		
Referring Provider NPI	x		
Referring Provider Payer ID	x		

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Rendering/Service Provider Country Name	x	x	
Rendering/Service Provider Name	x	x	
Rendering/Service Provider NPI	x	x	
Rendering/Service Provider Payer ID	x	x	
Rendering/Service Provider Rendering/Service Location City Name	x	x	
Rendering/Service Provider Rendering/Service Location State or Province	x	x	
Rendering/Service Provider Rendering/Service Location ZIP Code	x	x	
Rendering/Service Provider Specialty	x	x	
Rendering/Service Provider Street Address	x	x	
Rendering/Service Provider Tax ID	x	x	
Rendering/Service Provider Type (e.g., physician, APRN)	x	x	
TPL Medicare Allowed Amount	x	x	
TPL Medicare Coinsurance Amount	x	x	
TPL Medicare Deductible Amount	x	x	
TPL Medicare Paid Amount	x	x	
TPL Medicare Paid Date	x	x	
TPL Other Payers Allowed Amount - MCO to Supply All Other Payer Information	x	x	
TPL Other Payers Coinsurance Amount - MCO to Supply All Other Payer Information	x	x	
TPL Other Payers Deductible Amount - MCO to Supply All Other Payer Information	x	x	
TPL Other Payers Name - MCO to Supply All Other Payer Information	x	x	
TPL Other Payers Paid Amount - MCO to Supply All Other Payer Information	x	x	
TPL Other Payers Paid Date - MCO to Supply All Other Payer Information	x	x	
Note: Medical and Pharmacy are transaction specific encounter data sets; Member is a month specific file, and Provider file must represent present and historical provider network.			

MCO Coordination of Benefits Data Set Data Elements (From NH Medicaid Care Management Contract)
Medicaid Member Name
NH Medicaid Member ID
Insurance Carrier, PBM, or Benefit Administrator ID
Insurance Carrier, PBM, or Benefit Administrator Name
Date of Service
Claim ID (transaction code number)
Date billed to the insurance carrier, PBM, or benefit administrator
Amount billed
Amount recovered
Denial reason code
Denial reason description
Performing provider
Note: COB is a transaction specific data set submitted monthly in a delimited flat text file.

MCO to NH DHHS Provider File Data Elements (Version 0.2)
MCO ID (unique ID for the MCO that spans all MCO submitted data)
MCO Assigned Provider ID
MCO Group ID Number (if used)
Provider Certification Data (licensure, provider residency/fellowship, date and specialty of Board Certification status)
Provider In-Network Indicator
Provider Multiple Service Location Indicator
Provider Location Type (e.g., border, in-state, out-of state)
Provider ID NH Medicaid Assigned
Provider ID MCO Assigned
Provider NPI
Provider Taxonomy
Provider SSN/TIN

MCO to NH DHHS Provider File Data Elements (Version 0.2)
Provider DEA/CDS
Provider Organization or Individual?
Provider Organization Name (if non-person provider)
Provider Individual Last Name (blank if non-person provider)
Provider Individual First Name (blank if non-person provider)
Provider Individual Middle Name (blank if non-person provider)
Provider Individual Suffix (blank if non-person provider)
Provider Individual Degree (e.g., MD, CRNA) (blank if non-person provider)
Provider Specialty 1 (Primary)
Provider Specialty 2
Provider Specialty 3
Provider Specialty 4
Provider Associated Organization Name(s)
Provider Service Location(s) Street Address 1
Provider Service Location(s) Street Address 2
Provider Service Location(s) City Name
Provider Service Location(s) State or Province
Provider Service Location(s) ZIP Code
Provider Service Location(s) Country Name
Provider Service Location(s) County Name
Provider Service Location(s) Telephone Number
Provider Service Location(s) Latitude
Provider Service Location(s) Longitude
Provider Type (e.g., physician, APRN, group)
Provider Listed as Primary Care Provider in MCO Directory Flag
Number of Openings in Primary Care Provider Panel

MCO to NH DHHS Provider File Data Elements (Version 0.2)
Provider Appears in MCO Directory Flag
Non-primary care Practice: Open vs. Closed
Date Enrolled by MCO
Date Terminated by MCO
MCO Termination Reason
Provider Status (e.g., active, inactive, terminated, dead, etc.)
Provider Rendering of Service, Billing, or Both?
Provider Association to Organization(s)
Organizational or individual provider type
Medical/Health Home: yes vs. no
Credentialing related
Site visit date
Physical Accessibility and appearance/ADA compliant
Medical records: paper vs. electronic
Meeting meaningful use criteria: met vs. not met
Review by the appropriate accreditation organization
Medicare Provider Flag
Credentialed Medicaid Provider In Other State; indicate state
Active license; NH, other state
Malpractice Insurance: yes vs. no
Education and Work history validation: yes vs. no
National Practitioner Data Bank
License or Workplace Limits, Discipline, Loss of Privilege: Flag
License or Workplace Limits, Discipline, Loss of Privilege: Detail
Felony Conviction: yes vs. no
OIG Exclusion: yes vs. no

MCO to NH DHHS Provider File Data Elements (Version 0.2)
Tax Delinquency: yes vs. no
Criminal Background Check: criminal vs. non
Fingerprinting Required: yes vs. no
Additional Technical Requirements (Solutions Pending)
File(s) must represent present and historical provider network (i.e., changes in any data)
File(s) must allow individuals to be associated with multiple groups
File(s) must allow individuals to be associated with multiple service locations

Appendix D: NH Medicaid Care Management Contract Compliance with CMS Clinical Standards and Guidelines

The following table meets the requirement of 42 CFR 438.204(a) by itemizing the required components and identifies the reference for the contract provisions that incorporate the standards of 42 CFR 438 Subpart D in the NH Medicaid Care Management contract.

42 CFR Subpart D: Reference and Summarized Content	Contract Provision (NH Medicaid Care Management Contract Section Reference)
438.204 - Elements of state quality strategy	
• The State and the MCOs must assess the quality and appropriateness of care and services to all enrollees and individuals with special health care needs	• 22.1.3 • 17.1.5;, 17.1.13
• The State and the MCOs must identify race, ethnicity and primary language spoken.	
• The State must regular monitor MCO compliance with quality standards, including:	• 19.1.4
◦ National measures,	◦ 24
◦ Annual, external independent review,	◦ 23.1.1; 28
◦ The State's information systems, and	
◦ Standards at least as stringent as those in the Federal regulations, for access to care, structure and operation, and quality measurement and improvement.	
Access Standards	
438.206 - Availability of services	
• The MCO must maintain and monitor a delivery network supported by written agreements and is sufficient to provide adequate access to services covered under the contract to the population to be enrolled.	• 21.1.1
• The MCO must provide female enrollees direct access to women's health specialists.	• 19.4.1
• The MCO must provide for a second opinion.	• 19.7
• The MCO must provide out of network services when not available in network.	• 19.6
• The MCO must provide assurance that the costs to enrollees out-of-network are no greater than in-network.	• 19.6.3
• The MCO must demonstrate that providers are credentialed.	• 21.3
• The MCO must demonstrate that both the MCO and its providers furnish services with timely access and cultural competence.	• 21.1.4; 17.1.2
438.207 - Assurances of adequate capacity and services	
• The MCO must provide documentation that demonstrates it has capacity to serve the expected enrollment, submit the documentation in a format specified by the State at time of contracting and any time there is a significant change.	• 21.1.1
438.208 - Coordination and continuity of care	
• The MCOs must implement procedures to deliver primary care and coordinate health care services to enrollees.	• 10.1; 10.2; 10.3; 10.9
• The State must implement procedures to identify persons with special health care needs.	• 10.8.2

For individuals with special health care needs: • The MCOs must implement mechanisms for assessing enrollees identified as having special needs to identify ongoing special conditions and developing a treatment plan. • The MCOs must have a mechanism to allow persons identified with special health care needs to access specialty care directly (standing referral).	• 10.8 • 10.8.1
438.210 - Coverage and authorization of services • The MCOs must define the amount, duration and scope of services provided. • The MCOs must specify "medically necessary services." • The MCOs must have a service authorization process.	• 8.2.1; 8.2.4; 8.2.5
Structure and Operation Standards	
438.214 – Provider selection • The MCOs must implement written policies and procedures for selection and retention of providers. • The State must establish a uniform credentialing and recredentialing policy. MCO must follow a documented process for credentialing and recredentialing. • The MCOs cannot discriminate against providers that serve high-risk populations. • The MCOs must exclude providers who have been excluded from participation in Federal health care programs.	• 21.3 • 21.3 • 21.1.2
438.218 - Information Requirements • The State and MCOs must meet the requirements of 42CFR438.10	• 15.2.3; 16.1.2; 16.1.12
438.224 - Confidentiality • The MCOs must comply with all state and federal confidentiality rules.	• 30.1.4; 30.1.6
438.226 - Enrollment and disenrollment • The MCOs must comply with the enrollment and disenrollment standards in 42CFR438.56.	• 15
438.228 - Grievance systems • The MCOs must comply with grievance system requirements in 42CFR438 Subpart F. • The State will conduct random reviews of enrollee notification through its EQRO.	• 18 • 22.3; 22.3-Included into EQRO Scope of Work in development

438.230 - Subcontractual relationships and delegation • The MCOs are accountable for any functions or responsibilities that it delegates. • The MCOs must have a written agreement that regularly monitors and specifies the activities and report responsibilities that are delegated and specifies the revocation of the agreement if the subcontractor's performance is inadequate.	• 5.1 • 5.3
Measurement and Improvement Standards	
438.236 - Practice guidelines • The MCOs must adopt practice guidelines that are based on valid and reliable evidence or a consensus of health care professionals in the field; consider the needs of the population, are adopted in consultation with health care professionals, and are reviewed and updated periodically • The MCOs must disseminate guidelines. • The MCOs must apply guidelines to coverage decisions.	• 22.2.3
438.240 - Quality assessment and performance improvement (QAPI) program • Each MCO must have an ongoing QAPI program. • The MCOs conduct general performance measurement, including the detection of both under-utilization and over-utilization and an assessment of the quality and appropriateness of care furnished to enrollees with special health care needs. • The MCOs must measure and report to the State its performance using standard performance measures required by the state. Submit data specified by the State to measure performance. • The MCOs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. Projects should be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects should include: Measurement of performance using objective quality indicators, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the intervention, planning and initiation of activities for increasing or sustaining improvement. Each plan must report to the State the results of each project. • The State must review at least annually, the impact and effectiveness of the each program.	• 22.1.3; 22.1.3; 22.1.4; 22.1.5 • 22.1.6 • 22.1.11 • 22.4; 22.1.7; 22.1.4; 22.3 • Also included in EQRO Scope of Work

438.242 - Health information systems • The MCOs must have a system in place that collects, analyzes, integrates, and reports data and supports the plan's compliance with the quality requirements. • The MCOs collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system. • The MCOs must ensure that data from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, collecting service information in standardized formats, make all data available to the State and CMS. • Make the data available to the State and CMS.	• 24 • 22.5.3 • 24.1.4.3 • 25.1.1

Appendix E: NH Medicaid Care Management Program Routine Quality Reports

General reporting requirements:

Unless otherwise specified within the NH Medicaid contract, the following standard reporting requirements apply. The MCOs must hold subcontractors accountable to the Quality Strategy requirements for any data and reporting. *Last Updated 7.7.14. Consult with the Department for any recent updates prior to use.*

Distribution and Presentation:

- Daily reports must be available at 8:00 am Eastern Time, Tuesday through Sunday.
- Monthly reports must be available no later than the 10th calendar day of each month for the previous month's data.
- Quarterly reports must be available no later than the 10th calendar day following the end of the quarter.
- Annual reports must be available no later than the 30th calendar day following the end of the defined year (e.g. fiscal, calendar, quality, etc).
- Periodic reports must be aggregated into a consolidated report, i.e. all monthly reports distributed as a single monthly report, and presented to the DHHS account manager and the DHHS program subject matter contact.
- All reports must be provided in an electronic file that allows text and visual displays of information to be exported, edited and used by DHHS (e.g. graphs in PowerPoint, executive summaries exported into other documents, etc.)

Analysis:

- All reports should include outcome measures to the greatest extent possible in addition to structure and process measures,
- All reports should include quantitative assessments to the greatest extent possible in addition to any qualitative assessments,
- All reports should incorporate appropriate comparators which must be approved by DHHS prior to use, and
- All reports should include sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.

Baselines:

- Baselines for cost savings where necessary shall be the twelve (12) month period prior to the Agreement Year, or the twelve (12) month period prior to the new program initiative, but at no time may be greater than two (2) years prior to the program period being evaluated.
- Innovations in place for greater than twenty-four (24) months will have to baseline reset so that a new baseline is established for the second and for each subsequent twenty-four (24) month period of the initiative.

n.b. Reports noted are exclusive of the plans and reports exclusive to the initial implementation of the NH Medicaid Care Management program.

Report Category	Name	Description	Measure Data Period	Contract Reference
ACCESS	Timely Access Compliance Quarterly Report	Report documenting MCOs compliance with timely access standards	Quarterly	Ex O 1835
	Corrective Action Plan for Non-Compliance With Timely Access Standards	Corrective Action Plan if there is a failure to comply with timely access provisions of the NH Medicaid Care Management Contract	N/A	Contract reference 18.3.6
	Monitoring Access to Care Quarterly Report	The MCO shall analyze and report on Monitoring Access to Care in New Hampshire's Medicaid Program: MCO Access, to include all of the metrics measured and trended in the State's access reporting to CMS as MCO data is complete, including but not limited to: -Member requests for assistance accessing providers, total requests/1000 members, by metropolitan/non-metropolitan counties. -Quarterly enrollment by age, eligibility groups, metropolitan/non-metropolitan counties; -Primary care providers/pediatricians/OB-Gyn, member to provider ratios; -Numbers of primary care visits, total visits/1000 members, by eligibility groups and by metropolitan/non-metropolitan counties; -Emergency department utilization, total visits/1000 members, by aid categories, seasonally adjusted and by metropolitan/non-metropolitan counties;	Quarterly	Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
		-Inpatient utilization, total admissions/1000 members, by aid categories, seasonally adjusted and by metropolitan/non-metropolitan counties; -Ambulatory sensitive condition admissions, total admissions/1000 members, seasonally adjusted; -Annual HEDIS & CAHPS measures (reported and updated annually on normal HEDIS cycle), broken down by metropolitan and non-metropolitan counties and HEDIS age groups: well care, preventive or other ambulatory service, follow-up visit after mental health hospitalization.		
ADVISORYBOARD	Provider Advisory Board (PAB) Annual Report	Provider Engagement: The MCO shall provide a narrative report on provider engagement through the Provider Advisory Board (PAB) meetings including, but not limited to, PAB composition, meeting times, locations, agendas, and MCO program impact attributable to the PAB and meetings.	Agreement Year	Contract reference 19.4.1; 20.1.1; Quality Strategy
	Consumer Advisory Board (CAB) Annual Report	The MCO shall report on member engagement through the Consumer Advisory Board (CAB) and Regional member meetings including, but not limited to, CAB member composition, the number of members attending regional meetings, meeting times, locations, agendas, MCO program impact attributable to the CAB and meetings.	Agreement year	Contract reference 15.7; 20.1.1; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
APPEALS	Appeals Quarterly Summary Report	The MCO shall report on all appeals, including, but not limited to all matters handled by delegated entities including but not limited to: Number of and types of appeals (e.g. routine, expedited), the service/decision being appealed, characteristics of the appealing member, the MCO action, any corrective action or response to the appeal (e.g. quality improvement project, operations changes, etc.), the date filed and date of MCO, response including, but not limited to any requested extensions and the reason for the extension, whether benefit continuation was required during the appeals timeframe, whether an upheld denial or partial denial continued to Fair Hearing with the date and decision from the Fair Hearing, (Quarterly).	Quarterly	Contract reference 17.1.9; Quality Strategy
BEHAVIORAL HEALTH	Plan for Increasing Consent for Release of Information for Primary Care - Behavioral Health Care Coordination	MCO plan for increasing the likelihood of written member consent for release of information from primary care and behavioral health providers for the purposes of care coordination. Plan subject to DHHS review and approval. Plan updated annually.	N/A	Quality Strategy
	Consent for Release of Information for Primary Care - Behavioral Health Care Coordination Annual Report	The MCO shall report and analyze the consent release of information for Primary Care – Behavioral Health Coordination, including, but not limited to: - All instances in which consent was not given - If possible the reason for refusal of consent	Agreement year	Ex O 1440

Report Category	Name	Description	Measure Data Period	Contract Reference
	New Hampshire Hospital Homelessness Reduction Plan	A plan to decrease the likelihood of discharge from New Hampshire Hospital to a shelter or homelessness for subsequent agreement year (subject to DHHS review and approval), including any specific plans for the NHHPP population.	Agreement year	Contract reference 12.1.15.1
	New Hampshire Hospital Homelessness Quarterly Report	The MCO shall quarterly report on discharges from New Hampshire Hospital to shelters/homelessness including, but not limited to: -Number of discharges to homeless shelters and homelessness, -The reasons for discharge to the shelters or homelessness, -The efforts made by the MCO to arrange appropriate placements.	Quarterly	Ex O 229; Contract reference 12.1.15.1
	Olmstead Plan Support	Report on the MCO activities related to the NH Olmstead Plan, "Addressing the Critical Mental Health Needs of NH Citizens: A Strategy for Resolution", including any specific plans for the NHHPP population, including at minimum: -An assessment of the availability, use and need for Assertive Community Treatment Teams, by region and statewide, -Community residential capacity, by region and statewide, and -Community tenure strategies to address admissions and readmissions at New	N/A	Contract reference 12.1.8

Report Category	Name	Description	Measure Data Period	Contract Reference
		Hampshire hospital, for children and adults. Updated Annually.		
	Behavioral Health Satisfaction Survey Annual Report	Annually the MCO shall conduct and submit to DHHS an analytic narrative report that interprets the results from a consumer satisfaction survey for members with behavioral health conditions.	Annually	Ex O 1002; Quality Strategy
CARE MANAGEMENT	Care Management Plan	Overview of the MCO comprehensive care management and as assessment of MCO care management, with comprehensive care coordination across its health plan, other payers, fee-for-service Medicaid, community services and other health and social service providers; promoting and assuring service accessibility; centered on individual member and care giver needs with member and family involvement; community centered; culturally appropriate care, including special considerations for the NHHPP population; specifically including, but not limited to: -Care coordination, -Non-emergent transport, -Wellness and prevention, -Member health education, -Complex care member management, -Members with special needs. The Care Management Plan must include all of the elements addressed in each sub-section of Section 10. For any delegated tasks, the MCO must provide the reason for delegation, the	N/A	Contract reference 10; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
		tasks being delegated, how the determination and assurance of quality operations and/or services was made. Any delegated activities must be comprehensively compliant with the reporting in the Quality Strategy and specifically with the Care Management Plan and reporting. For each Agreement year after Year I, the MCO shall include in the Care Management Plan a quantitative, data driven and, to the extent possible, statistically valid assessment of the prior year's successes and new opportunities to improve the Care Management program, member health outcomes, and member and family experience of care. Any measures not otherwise specified in the NH Medicaid MCO contract and used for Care Management assessment must have prior approved from DHHS and should draw from national quality measurement experience to the greatest extent possible.		
	Systems of Care for Children With Serious Emotional Disturbance Quarterly Report	Report on MCO care management activities that ensure member and family involvement in the development of a system of care for children with serious emotional disturbance.	Quarterly	Contract reference 10.1.3; Quality Strategy
CLAIMS	Claims Payment Quality Assurance Corrective Action Plans	Corrective Action Plans will identify any issues and/or errors identified during claim reviews and report on a resolution to DHHS.	N/A	Ex O 1058

Report Category	Name	Description	Measure Data Period	Contract Reference
	Administrative Claims Quality Assurance Standards Summary Quarterly Report	The MCO shall routinely measure the accuracy of claims processing and report results to DHHS including but not limited to: -Adjudication of claims: 95% of clean claims within thirty (30) days of receipt -Financial accuracy: 99%, -Claims accuracy: 95% -A review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims, -Corrective action plans needed to address claims payment accuracy issues.	Quarterly	Contract reference 27; 27.1.1; 27.2.1; 27.3; 27.4; 27.5; Quality Strategy
COMMUNICATION	Communications Plan	Communications Plan is a written strategy for timely notification to DHHS regarding expected or unexpected interruptions or changes that impact MCO policy, practice, operations, members or providers. The Communication Plan shall define the purpose of the communication, the paths of communication, the responsible MCO party required to communicate, and the time line and evaluation of effectiveness of MCO messaging to DHHS. The Communications Plan shall also provide for the MCO's response to correspondence received from DHHS staff within one (1) business day of receipt.	N/A	Contract reference 2; 7.4.2

Report Category	Name	Description	Measure Data Period	Contract Reference
CULTURAL COMPETENCY	Cultural Competency Strategic Plan	MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by the community assessments and profiles.	N/A	Quality Strategy
	Cultural Competency Annual Report	The MCO shall report on the following activities related to the culturally appropriate delivery of services: -Member race, ethnicity and primary spoken and written language of its members, -Community demographic, cultural and epidemiologic profile to address the cultural and linguistic characteristics of each of the MCO's services areas, -Utilization of interpreter services for health plan service and medical services provided by its provider network, including, but not limited to the number of interpreters used and the number declined, -Activities undertaken as a part of the MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by the service area community assessment.	Agreement year	Contract reference 16.1.5; 16.1.7; 16.1.13.8; 16.1.13.11, Quality Strategy
EMERGENCY RESPONSE	Emergency Response Plan	Description of MCO planning in the event of an emergency to ensure ongoing, critical MCO operations and the assurances to meet critical member health care needs,	N/A	Contract reference 7.5

Report Category	Name	Description	Measure Data Period	Contract Reference
		including, but not limited to, specific pandemic and natural disaster preparedness.		
EPSDT	EPSDT Plan	MCO EPSDT plan that includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure compliance with the EPSDT periodicity schedules including NHHPP members covered by EPSDT.	N/A	Contract section 11
FINANCIAL STATEMENT	Audited Financial Statement	The MCO shall provide DHHS a complete copy of its audited financial statements and amended statements	Annually	Contract reference 29.7, Quality Strategy
FRAUD WASTE ABUSE	Comprehensive Annual Fraud Waste and Abuse Summary Annual Report	Comprehensive Annual Fraud Waste and Abuse (FWA) Summary Narrative Report including MCO internal recommendations as applicable based on summary analysis to mitigate FWA	Agreement Year	Ex O 1057
GRIEVANCE	Grievance Summary Quarterly Report	The MCO shall report on all grievances, including, but not limited to all matters handled by delegated entities including but not limited to: -Number of grievances, categories of grievance, member or provider characteristics grieving, any corrective action or response to the grievance (e.g. quality improvement project, operations changes, etc.), the date of filing and date of MCO response, (Quarterly), -Complete copies of grievances alleging discrimination related to race, color, creed, sex, religion, age, national origin, ancestry, marital	Quarterly	Contract reference 17.1.9; 26.2.2.4; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
		status, sexual or affectional orientation, physical or mental disability (three days of MCO receipt)		
NH HEALTH PROTECTION PLAN REPORTS	Consent for Release of Information for Primary Care - Behavioral Health Care Coordination Annual Report - NHHPP Members	The MCO shall report and analyze the consent release of information for Primary Care – Behavioral Health Coordination, including, but not limited to: - All instances in which consent was not given - If possible the reason for refusal of consent	Agreement year	Ex O
	New Hampshire Hospital Homelessness Quarterly Report - NHHPP Members	The MCO shall quarterly report on discharges from New Hampshire Hospital to shelters/homelessness including, but not limited to: -Number of discharges to homeless shelters and homelessness, -The reasons for discharge to the shelters or homelessness, -The efforts made by the MCO to arrange appropriate placements.	Quarterly	Ex O
	Behavioral Health Satisfaction Survey Annual Report - NHHPP Members	Annually the MCO shall conduct and submit to DHHS an analytic narrative report that interprets the results from a consumer satisfaction survey for members with behavioral health conditions - NHHPP Members	Annually	Ex O
	Member Communications Summary Quarterly Report - NHHPP	The MCO shall report on: -Number of new member welcome calls, including,	Quarterly	Ex O

Report Category	Name	Description	Measure Data Period	Contract Reference
	Members	but not limited to the total number of calls made, the number of successful calls, the number of unsuccessful attempts, -Number of initial enrollment letters and member handbooks mailed and received back as undeliverable -MCO member website with additional information on website use including, but not limited to, Number of hits to the website, time spent on the website, document downloads, requests for additional information, email use – number, proportion of contacts via email and reasons for email, email response statistics, maintenance and update events -Inbound member call center utilization, (e.g. calls received, reason for the call, speed to answer, hold times, total call time, calls abandoned, voice messages left during and after business hours, etc.), -Transferred member calls including, but not limited to the number of warm transfers, the program transferred to, any follow undertaken, etc., -After hours voice mail follow up, including, but not limited to the number and reason for the after-hours calls, the date and time of the call, and the date and time of the returned calls by the next business day,		

Report Category	Name	Description	Measure Data Period	Contract Reference
	Non-Emergent Transportation Summary Quarterly Report - NHHPP Members	Report on Non-Emergent Transportation (NEMT) to include, but not be limited to: -Types of NEMT used, -Number of members transported via NEMT, and -Requested, completed and not provided when requested NEMT events.	Quarterly	Ex O
	Pharmacy Management Operations Standards Summary Quarterly Report - NHHPP Members	The MCO shall report on pharmacy services operations standards and must maintain response times of: -95% of electronic systems transactions less than one (1) second, -24 hours to a request for prior authorization, -Call Center customer services (e.g. inbound calls received, speed to answer, hold times, total call time, calls abandoned, etc.).	Quarterly	Ex O
	Pharmacy Payments Summary Quarterly Report - NHHPP Members	The MCO shall report on pharmacy payments, including but not limited to: - Total pharmacy claims and dollars paid, voided/reversed, denied, - Number of members accessing pharmacy services, by member characteristics such as age, eligibility group, gender, etc., - Average, median and range of the number of prescriptions per user, - Average, median and range of prescription claims and net cost in dollars per	Quarterly	Ex O

Report Category	Name	Description	Measure Data Period	Contract Reference
		user, and by member characteristics such as age, eligibility group, gender, etc., - Drugs subject to a maximum allowable cost (MAC), the cost avoidance of MAC application, - Co-payment required/not required, collected/not collected, - Over the counter drug use by various parameters.		
	Pharmacy Management Utilization Controls Summary Quarterly Report - NHHPP Members	The MCO shall report on pharmacy utilization controls including but not limited to: -Prior authorizations, number, approved, denied, partially approved, -Generic utilization, including, but not limited to the percentage of generics/ all drugs, the percentage of generics / all drugs for which a generic is available and the brand is not required by the NH PDL, percentage of generics/ all drugs for which a generic is available, -Mail order pharmacy use if any, -Rankings by various parameters (e.g. claim count, payment amount, average payment) for, but not limited to: Top 50 member, Top 50 drug, Top 20 therapeutic class use, Top 50 ingredient, Top 50 prescriber, Top 50 pharmacy, - PDL utilization by various parameters (e.g. member,	Quarterly	Ex O

Report Category	Name	Description	Measure Data Period	Contract Reference
		prescribers, therapeutic class, etc.).		
	Pharmacy Quality Improvement Initiatives Annual Summary Report - NHHPP Members	The MCO shall report on MCO Pharmacy Quality Improvement initiatives, including at minimum: - Polypharmacy for physical and behavioral health medications, - Maintenance medication adherence to eliminate gaps in refills, - Use and reimbursement of child psychiatric consultation for behavioral health medications in children, and - Other MCO initiated programs. For each initiative, the MCO must provide objective outcomes and at the end of each Agreement year, a sufficient detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.	Annual	Ex O

Report Category	Name	Description	Measure Data Period	Contract Reference
	Pharmacy Quality Improvement Initiatives Semi-Annual Summary Update Report - NHHPP Members	The MCO shall report an update on MCO Pharmacy Quality Improvement initiatives, including at minimum: - Polypharmacy for physical and behavioral health medications, - Maintenance medication adherence to eliminate gaps in refills, - Use and reimbursement of child psychiatric consultation for behavioral health medications in children, and - Other MCO initiated programs. For each initiative, the MCO must provide objective outcomes and at the end of each Agreement year, a sufficient detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.	Semi-Annual	Ex O
	Substance Use Disorder Benefit Quarterly Report: Summary Analytic Report of SUD Benefit		Quarterly	Ex O New
	Utilization Management Impact Annual Report - NHHPP Members	Annual narrative report which shall include, but not be limited to, an assessment of the impact of utilization controls on Beneficiary, provide and program quality and costs; any unintended consequences; an assessment of any under-utilization and/or over-utilization; opportunities for improvement; impact of Beneficiary and/or	Agreement Year	Ex O

Report Category	Name	Description	Measure Data Period	Contract Reference
		providers on changes to utilization controls		
	Utilization Management Summary Quarterly Report - NHHPP Members	The MCO shall report on services utilization and controls including but not limited to: -Prior authorizations, number requested, service requested (e.g. DME, hospitalization, service limit override, etc) approved, denied, partially approved, -Utilization controls decision making time frames for routine, urgent, continuation/extended, post service delivery -Sites and types of services, (e.g. acute hospital, home health, transplants, readmissions, high risk obstetric cases, etc.) by total number and normalized (e.g. number of services/ x members, number of services / PMPM), -Service utilization by various parameters (e.g. members eligibility group, member age, service provider, geographic site, etc.), -Rankings and trends by various parameters (e.g. utilization counts, payment amounts, average payments, etc.), -Annually reporting shall include, but not be limited to, an assessment of the impact of utilization controls on member, provide and program	Quarterly	Ex O

Report Category	Name	Description	Measure Data Period	Contract Reference
		quality and costs; any unintended consequences; an assessment of any under-utilization and/or over-utilization; opportunities for improvement; impact of member and/or providers on changes to utilization controls.		
IMPLEMENTATION	MCO Step 2 Program Implementation Plan	TBD - Placeholder	N/A	Contract reference 7.7
INTEGRITY	Program Integrity Plan	Plan for program integrity which shall include, at a minimum, the establishment of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse, as required in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438.	N/A	Contract reference 24.1.1
MCISPLANS	Managed Care Information System Contingency Plans	MCO shall annually submit its managed care information system (MCIS) plans to ensure continuous operation of the MCIS covering at a minimum the following: -Contingency plan for risk management to ensure continuous operation of the MCIS -Plan and design for joint interface to ensure continuous operation of the MCIS	N/A	Contract reference 22.5.12.5; 22.5.12.6; 22.5.17.2

Report Category	Name	Description	Measure Data Period	Contract Reference
		-Plan for and status of ICD-10 implementation and compliance -Contingency plan for disaster recovery -Plan for data security including preventive, detective, corrective controls and HIPPA compliance -Plan for confirmation of IRS publication 1075 -Plan for confirmation of 5010 compliance and companion guide -Contingency plan for business continuity		
MEMBER COMMUNICATION	Member Communications Summary Quarterly Report	The MCO shall report on: -Number of new member welcome calls, including, but not limited to the total number of calls made, the number of successful calls, the number of unsuccessful attempts, -Number of initial enrollment letters and member handbooks mailed and received back as undeliverable -MCO member website with additional information on website use including, but not limited to, Number of hits to the website, time spent on the website, document downloads, requests for additional information, email use – number, proportion of contacts via email and reasons for email, email response statistics, maintenance and update events	Quarterly	Contract reference 15.1.3; 15.1.4; 15.1.12; 15.4.5. 22.5.11; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
		-Inbound member call center utilization, (e.g. calls received, reason for the call, speed to answer, hold times, total call time, calls abandoned, voice messages left during and after business hours, etc.), -Transferred member calls including, but not limited to the number of warm transfers, the program transferred to, any follow undertaken, etc., -After hours voice mail follow up, including, but not limited to the number and reason for the after-hours calls, the date and time of the call, and the date and time of the returned calls by the next business day - Any special information related to the NHHPP program		
TRANSPORTATION	Non-Emergent Transportation Summary Quarterly Report	Report on Non-Emergent Transportation (NEMT) to include, but not be limited to: -Types of NEMT used, -Number of members transported via NEMT, and -Requested, completed and not provided when requested NEMT events.	Quarterly	Contract reference 10.4; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
NETWORK	Comprehensive Provider Network Filing Annual Report	The MCO shall report on the adequacy of its provider network including but not limited to: -An assessment of the member demographics and anticipated medical services need including, but not limited to a community level assessment of services available and community level barriers to medical services, -Provider access anticipated needs, including, but not limited to number, mix and geographic distribution to meet anticipated member needs, -Provider participation report: provider participation reports by geographic location, categories of service, provider type categories, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze provider service capacity in terms of realized member access to health care, -Any MCO provider network exceptions requested and the DHHS response, -Timely access to service delivery NH Medicaid Care Management contract standards for transition care after hospital or institutional discharge; preventive, routine, urgent and emergent care; -Data to support access to a choice of primary care	Agreement Year	Contract reference 18.2; 19.2.16; 19.2.18; 22.5.19

Report Category	Name	Description	Measure Data Period	Contract Reference
		provides, and access to women's health, family planning and special services, -*Data to support accessibility to providers for members with disabilities, -*Description of the number and type of services provided out of network, -Any corrective actions needed restore provider network adequacy to meet federal and state standards. -Any special considerations for the NHHPP members As part of the Comprehensive Annual Provider Network Filing, and as the need for them occurs, the MCO shall request in detail any needed exceptions to the network standards and provider a detailed plan including timelines to address the exception. One or more exceptions may be combined in the same document.		
	Provider Network Quarterly Update Report	The MCO shall report quarterly an overview of its provider network including but not limited to updates to aggregate information on the data elements contained in the annual network filing (NETWORK.01) including, but not limited to, the following data elements: -Number of providers terminated and number of providers newly enrolled by specialty, location, number of members affected,	Quarterly	Contract reference 18.2; 19.2.16; 19.2.18; 22.5.19

Report Category	Name	Description	Measure Data Period	Contract Reference
		-Geographic location of providers (by provider type, including NHHPP specific providers) and members, -Any transition plans needed to address any significant changes in the provider network		
	Corrective Action Plan to Restore Provider Network Adequacy	Corrective Action Plan if there is a need for corrective actions to restore provider network adequacy to meet federal and state standards.	N/A	Ex O 1036
NH HOSPITAL	New Hampshire Hospital Reductions in Readmission Plan	The MCO shall submit a plan and report on how the MCO shall reduce readmission to New Hampshire Hospital, including any special considerations for NHHPP members, including, but not limited to: -The development of a discharge plan, -Member receipt of the discharge plan, -Contact with the member within 3 calendar days of discharge, -A follow up appointment within 7 calendar days, -An assessment of the barriers to discharge and a plan to reduce the barriers and improve community tenure in the subsequent Agreement year, plan is subject to prior review and approval from DHHS. Updated annually.	N/A	Contract Reference 12.1.16.6

Report Category	Name	Description	Measure Data Period	Contract Reference
	Reduction in Readmissions to NH Hospital Summary Quarterly Report	The MCO shall report on how the MCO shall reduce readmission to New Hampshire Hospital, including any special considerations for NHHPP members, including, but not limited to: -The development of a discharge plan, -Member receipt of the discharge plan, -Contact with the member within 3 calendar days of discharge, -A follow up appointment within 7 calendar days, -Readmission rates	Quarterly	Contract reference 12.1.16; Quality Strategy
PAYMENT REFORM	Payment Reform Plan	Annual overview of the MCO Payment Reform Initiative plan for upcoming agreement year including but not limited to: -Brief description of the Payment Reform Initiative inclusive of program goals, member health outcomes, and providers affected, -For each provider group within the program: covered services not furnished by provider groups with the program, the type of incentive arrangement, the percentage of withhold or bonus, panel size and methodology used for assignment or pooling, adequate coverage of stop loss coverage if at financial risk.	N/A	Ex O 1077; Contract section 9

Report Category	Name	Description	Measure Data Period	Contract Reference
	Payment Reform Annual Report	Annual executive summary of annual of the MCO Payment Reform Initiative incorporating and use of sufficiently detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, successes and opportunities. Year I shall address implementation of the Payment Reform Initiative inclusive of measurable implementation milestones, subsequent years shall address program results. Comment and compliance with the requirements set forth in Section 9.1.5, including, but not limited to, rates paid, federal regulation, requests for program information.	Agreement year	Contract reference 9; Quality Strategy
	Payment Reform Quarterly Update Report	Describe the progress made toward implementation of the MCO Payment Reform Plan, including, but not limited to: -Brief description of the payment reform initiatives inclusive of program goals, member health outcomes, and providers affected, -Executive summary of progress toward implementation, any correction or challenges being encounter and how those challenges are being addressed, -Sufficient detail to accurately assess progress toward each implementation goal, an analysis of any challenges or corrective action and how those challenges or changes will be addressed.	Quarterly	Contract reference 9, 9.1.4; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
PHARMACY	Pharmacy Management Operations Standards Summary Quarterly Report	The MCO shall report on pharmacy services operations standards and must maintain response times of: -95% of electronic systems transactions less than one (1) second, -24 hours to a request for prior authorization, -Call Center customer services (e.g. inbound calls received, speed to answer, hold times, total call time, calls abandoned, etc.).	Quarterly	Contract reference 13.1.8; 13.1.9; Quality Strategy
	Pharmacy Payments Summary Quarterly Report	The MCO shall report on pharmacy payments, including but not limited to: - Total pharmacy claims and dollars paid, voided/reversed, denied, - Number of members accessing pharmacy services, by member characteristics such as age, eligibility group, gender, etc., - Average, median and range of the number of prescriptions per user, - Average, median and range of prescription claims and net cost in dollars per user, and by member characteristics such as age, eligibility group, gender, etc., - Drugs subject to a maximum allowable cost (MAC), the cost avoidance of MAC application, - Co-payment required/not required, collected/not collected,	Quarterly	Contract reference 13; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
		- Over the counter drug use by various parameters.		
	Pharmacy Management Utilization Controls Summary Quarterly Report	The MCO shall report on pharmacy utilization controls including but not limited to: -Prior authorizations, number, approved, denied, partially approved, -Generic utilization, including, but not limited to the percentage of generics/ all drugs, the percentage of generics / all drugs for which a generic is available and the brand is not required by the NH PDL, percentage of generics/ all drugs for which a generic is available, -Mail order pharmacy use if any, -Rankings by various parameters (e.g. claim count, payment amount, average payment) for, but not limited to: Top 50 member, Top 50 drug, Top 20 therapeutic class use, Top 50 ingredient, Top 50 prescriber, Top 50 pharmacy, - PDL utilization by various parameters (e.g. member, prescribers, therapeutic class, etc.).	Quarterly	Contract reference 13; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
	Pharmacy Quality Improvement Initiative Plans	Annual Pharmacy Quality Improvement Initiative Plans, including any plans specific to the NHHPP members, that will at a minimum include the following initiatives: - Polypharmacy for physical and behavioral health medications, - Maintenance medication adherence to eliminate gaps in refills, - Use and reimbursement of child psychiatric consultation for behavioral health medications in children, and - Other MCO initiated programs. For each initiative, the MCO must provide objective outcomes and at the end of each Agreement year, a sufficient detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.	Annual Plan	Contract reference 13.1.10
	Pharmacy Quality Improvement Initiatives Annual Summary Report	The MCO shall report on MCO Pharmacy Quality Improvement initiatives, including at minimum: - Polypharmacy for physical and behavioral health medications, - Maintenance medication adherence to eliminate gaps in refills, - Use and reimbursement of child psychiatric consultation for behavioral health medications in	Annual	Contract reference 13.1.10; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
		children, and - Other MCO initiated programs. For each initiative, the MCO must provide objective outcomes and at the end of each Agreement year, a sufficient detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.		
	Pharmacy Quality Improvement Initiatives Semi-Annual Summary Update Report	The MCO shall report an update on MCO Pharmacy Quality Improvement initiatives, including at minimum: - Polypharmacy for physical and behavioral health medications, - Maintenance medication adherence to eliminate gaps in refills, - Use and reimbursement of child psychiatric consultation for behavioral health medications in children, and - Other MCO initiated programs. For each initiative, the MCO must provide objective outcomes and at the end of each Agreement year, a sufficient detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.	Semi-Annual	Contract reference 13.1.10; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
PERFORMANCE IMPROVEMENT PROJECT	Performance Improvement Project Semi-Annual Report	The MCO shall report the status and results including but not limited to: -Brief description of each PIP, PIP goals and progress toward each goal, -Sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.	Semi-Annual	Contract reference 20.1.11; Quality Strategy
PROGRAM MANAGEMENT PLAN	Program Management Plan	The Project Management Plan shall elaborate on the general concepts outlined in the MCO's proposal and the categories of Exhibit A. The PMP shall describe how the MCO will operate in New Hampshire by outlining management processes such as communications, workflow, overall systems as detailed in the categories of Exhibit A, evaluation of performance, and key operating premises for delivering efficiencies and satisfaction as they relate to member and provider experiences. The PMP shall outline the MCO integrated organizational structure including New Hampshire-based resources and its support from corporate, subcontractors, and workgroups or committees.	N/A	Contract reference 2; 7.4.1
PRIVACY BREACH	Privacy Breach Notification	The MCO shall preliminarily report any suspicion of any violation of protected health information with one (1) day of receipt of any information suggesting any violation to DHHS and provide final detailed notice after MCO assessment	As Needed	Contract reference 28

Report Category	Name	Description	Measure Data Period	Contract Reference
PROVIDER COMMUNICATION	Provider Communications Summary Quarterly Report	The MCO shall report on: - Any special information related to the NHHPP program	Quarterly	
PROVIDER SATISFACTION	Provider Satisfaction Survey	The MCO shall conduct and submit to DHHS an analytic narrative report that interprets the results from an annual provider satisfaction survey. Survey instrument to be approved by DHHS and administered by a third party and be based on a statistically valid sample of each major provider type: PCP, specialists, hospitals, pharmacies, DME, and Home Health. DHHS is to have input into the development of each year's survey.	Semi-Annual First Year, Then Annual	Ex O 1046; Contract reference 19.4.2.
PROVIDER TRAINING	Provider Training Annual Report	The MCO shall report on: -Provider training, including, but not limited to the date and location, subject of the training, number in attendance, training evaluation, and include in this report presentation the Behavioral Health: Mental Health Service Providers Training Reporting, -Provider relations strategy, including, but not limited to the provider relations staff information, provider relations activates, and the impact of those activities, -Inbound provider call utilization, (e.g. inbound calls received, reason for the call, speed to answer, hold times, total call time, calls abandoned, voice messages left during and after business hours, etc.),	Agreement Year	Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
		-After hours voice mail follow up, including, but not limited to the number and reason for the after-hours calls, the date and time of the call, and the date and time of the returned calls by the next business day, -Number of hits on the MCO provider website with additional information on website use including, but not limited to but not limited to the number and proportion of utilization controls managed through the website, e-prescribing, document downloads, requests for additional information, email use – number, proportion of contacts via email and reasons for email, email response statistics, maintenance and update events.		
	Community Mental Health Center Staff Training Plan	MCO plan on how the MCO shall support the community mental health system hire, train and retain qualified staff. For any delegated tasks, the MCO must provide the reason for delegation, the tasks being delegated, how the determination and assurance of quality operations and/or services was made. Any delegated activities must be comprehensively compliant with reporting needs.	N/A	Contract reference 12.1.10
	Community Mental Health Center Staff Training Annual Report	The MCO shall submit a report on how the MCO has supported the community mental health system to hire, train and retain qualified staff, including, but not limited to:***Type of training provided with participant list, summary of	Agreement Year	Contract reference 12.1.10; Quality Strategy

Report Category	Name	Description	Measure Data Period	Contract Reference
		activity and evaluation of the training, ***How evidence based practices are sustained and/or expanded upon, including specific comment on each of the practices listed in 12.1.10.3,***Suicide prevention and post-intervention training, and***An assessment of training strengths and opportunities with how those opportunities will address in the subsequent Agreement Year.		
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT REPORTS	Quality Assessment and Performance Improvement (QAPI) Annual Summary Report	Narrative Report on status of Quality Assessment and Performance Improvement (QAPI) program including: Annual objectives and goals, outcome measures, quantitative assessments, incorporate appropriate comparators which must be approved by DHHS prior to use, demonstrate program impact, success and opportunities using detailed, data driven assessments using statistically sound measurement and analysis, under and/or over-utilization, and an assessment of the quality and appropriateness of care for Beneficiaries with special needs. Included in the annual summary the MCO shall report the status and results of performance improvement projects. Any special information concerning the NHHPP population will also be reported on in this summary as applicable.	Annually	Contract reference 20.1.7; 20.1.11; 20.1.13; 20.4; 20.1.11

Report Category	Name	Description	Measure Data Period	Contract Reference
	Quality Assessment and Performance Improvement (QAPI) Semi-Annual Update Report	Semi-Annual update on status of Quality Assessment and Performance Improvement (QAPI) program including: Annual objectives and goals, outcome measures, quantitative assessments, incorporate appropriate comparators which must be approved by DHHS prior to use, demonstrate program impact, success and opportunities using detailed, data driven assessments using statistically sound measurement and analysis, under and/or over-utilization, and an assessment of the quality and appropriateness of care for Beneficiaries with special needs. Included in the annual summary the MCO shall report the status and results of performance improvement projects. Any special information concerning the NHHPP population will also be reported on in this summary as applicable.	Semi-Annual	Contract reference 20.1.7; 20.1.11; 20.1.13; 20.4; 20.1.11
QUALITY INCENTIVE PROGRAM REPORTS	Quality Incentive Program Semi-Annual Progress Report	The MCO shall report the point in time status and results of each annual Quality Incentive Program (QIP) initiative including but not limited to: -Brief description of each QIP, QIP goals and progress toward each goal, -Sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities. Any special information concerning the NHHPP	Semi-Annual	Contract reference 20.6

Report Category	Name	Description	Measure Data Period	Contract Reference
		population will also be reported on in this summary as applicable.		

Appendix F: Abbreviations and Acronyms

AHRQ	Agency for Healthcare Research and Quality
BRFSS	Behavioral Risk Factor Surveillance System
CAHPS	Consumer Assessment of Health Providers and Systems
CDC	Center for Disease Control and Prevention
CFR	Code of Federal Regulations
CHIS	Comprehensive Health Care Information System
CMS	Center for Medicare and Medicaid Services
DHHS	Department of Health and Human Services
EQRO	External Quality Review Organization
HEDIS	Healthcare Effectiveness Data and Information Set
HER	Electronic Health Record
HIE	Health Information Exchange
HITECH	Health Information Technology for Economic and Clinical Health
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MQIS	Medicaid Quality Information System
NCQA	National Committee for Quality Assurance
NH	New Hampshire
PIP	Performance Improvement Program
QAPI	Quality Assurance Performance Improvement
QIP	Quality Incentive Project
SAMHSA	Substance Abuse and Mental Health Services Administration